

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Montg.

63086

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

Village or City Layhill (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Edward C. Alderton

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married.  
(Write the word)

6 DATE OF BIRTH July 17, 1887  
(Month) (Day) (Year)

7 AGE 42 yrs. 8 mos. 1 ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) West Va.

10 NAME OF FATHER James W. Alderton

11 BIRTHPLACE OF FATHER (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Martha E. Trull

13 BIRTHPLACE OF MOTHER (State or Country) W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Edward C. Alderton

(Address) Layhill, Md.

15 Filed Mar 19, 1930 W. L. Luns  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 18, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 18, 1930 to March 18, 1930  
that I last saw him alive on March 16, 1930

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Tuberculosis of the lungs

(Duration) 3 yrs. 3 mos. 1 ds.

Contributory Secondary Tuberculosis of the lungs

(Duration) 2 yrs. 3 mos. 1 ds.

Signed) W. L. Luns M. D.

March 19, 1930 (Address) Washington

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brentinville Cemetery 3, 20, 1930

20 UNDERTAKER

ADDRESS

Warner E. Humphrey, Rockville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material word on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1930

BUREAU

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Takoma Park (No. Washington 522 & Ward 82)

2 FULL NAME Miss Mary Allen

06813

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 229

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Nov. 1, 1872  
(Month) (Day) (Year)

7 AGE 57 yrs. 7 mos. 24 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Washington D.C.

10 NAME OF FATHER Thomas Allen

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cronikan

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanitarium Records

(Address) Takoma Park, Md.

15 Filed June 25, 1920 H. C. Rogers Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 25, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 8, 1920 to June 25, 1920.

that I last saw her alive on June 25, 1920.

and that death occurred on the date stated above, at 6:32 a.m.

The CAUSE OF DEATH \* was as follows:

Hypertensive Cardiovascular Disease - Hemiplegia  
Indefinite (Duration) yrs. mos. ds.  
Contributory Second Cerebral Hemorrhage  
Secondary

(Signed) Chas. W. G. Tolson M. D.  
6/25/1920 (Address) Takoma Park, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. 17 ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1331-15th St. N.W. Washington, D.C.

19 PLACE OF BURIAL OR REMOVAL Washington D.C. DATE OF BURIAL June 25, 1920

20 UNDERTAKER J. W. (Chas) G. Tolson ADDRESS Chapin

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Lumber—Cord mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia," "Typhoid pneumonia, Bronchopneumonia" ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little extra is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 5 1930  
BUREAU



MARGIN RESERVED FOR BINDING

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County MD

Village or City Fiber Spring (No. 90)

06814 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 214

2 FULL NAME Walter Allen

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH June 5, 1847  
(Month) (Day) (Year)

7 AGE 83 yrs. 11 mos. 2 ds. or less than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Lawyer  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) England

10 NAME OF FATHER Wm W. Waller

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Knight

13 BIRTHPLACE OF MOTHER (State or Country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lunian Hawland

(Address) Fiber Spring, MD

15 Filed June 2, 1930 J. E. Dudley  
Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 2, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 15, 1929 to June 2, 1930  
that I last saw him alive on June 2, 1930  
and that death occurred on the date stated above, at 6:45 m.  
The CAUSE OF DEATH \* was as follows:

Myocarditis

(Duration) 3 yrs. 0 mos. 0 ds.

Contributory arterio-sclerosis  
Secondary

(Duration) 20 yrs. 0 mos. 0 ds.

(Signed) J. B. Harrison M. D.

June 2, 1930 (Address) Fiber Spring, MD

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 5 yrs. 14 mos. 14 ds. In the State MD yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence DC

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Washington D.C. June 2, 1930

20 UNDERTAKER ADDRESS

John R. Knight Co 1837-10-175th

If more blanks are needed, address State Registrar, 16 W. Saratogo St., Balto., Requesting V. S. No. 15 Wash. D.C.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archdeacon, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Sprinter, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

UNIVERSITY OF MICHIGAN  
JUN 25 1950  
C. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Darrowsville (No.     )

2 FULL NAME Lawrence Allmuth

09371  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 212

St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH 10 18 1859  
(Month) (Day) (Year)

7 AGE 70 yrs. 1 mos. 24 ds. or      min.?  
(If LESS than 1 day, hrs.)

8 OCCUPATION  
(a) Trade, profession or particular kind of work Merchandizing  
(b) General nature of industry business, or establishment in which employed or (employer) Genl. Merchant

9 BIRTHPLACE (State or country) Montg. Co. Md

10 NAME OF FATHER Nathan W. Allmuth

11 BIRTHPLACE OF FATHER (State or country) Montg Co

12 MAIDEN NAME OF MOTHER Margd. White

13 BIRTHPLACE OF MOTHER (State or country) Montg Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ella V. Allmuth

(Address) Darrowsville Md

15 Filed Aug 12 1930 E. W. White  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8 12 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 12 1930 to Aug. 12 1930.

that I last saw him alive on Aug 12 1930.

and that death occurred on the date stated above, at 9 P.m.

The CAUSE OF DEATH was as follows:

Thrombosis of the Coronary artery.

Contributory Chronic Myocarditis  
Secondary (Duration) 1.4 yrs. 1 mos. 4 ds.

(Signed) Upton D. Worsley M. D.  
Aug 13 1930 (Address) Darrowsville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death      yrs.      mos.      ds. In the State      yrs.      mos.      ds.

Where was disease contracted, if not at place of death?

Former or usual residence     

19 PLACE OF BURIAL OR REMOVAL Boallsville Md DATE OF BURIAL Aug 14 1930

20 UNDERTAKER Hilton and Hall ADDRESS Poolersville Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

12538

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City Jakoma Park (No. 50)

Elm Av.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME in- stead of street and number.)

2 FULL NAME Armistead

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH October 18, 1930  
(Month) (Day) (Year)

7 AGE still birth If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) none

9 BIRTHPLACE (State or country) 50 - Elm Av. Jakoma Park

10 NAME OF FATHER Thomas W. Armistead

11 BIRTHPLACE OF FATHER Dublin, Georgia  
(State or country)

12 MAIDEN NAME OF MOTHER Grace May Reynolds

13 BIRTHPLACE OF MOTHER Norris town. Pa.  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo W. Armistead  
(Address) Jakoma Park

15 Filed Oct 18 1930 H. E. Rogers Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 18, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 18 1930 to Oct 18 1930,

that I last saw him alive on no date, 1930

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Stillbirth

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory Strangulation of cord (intra-uterine)  
Secondary (Signed) Stuart B. Johnson M. D.  
Oct 18 1930 (Address) 5714-14th N.W. Wash DC

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Richmond Va DATE OF BURIAL Oct 19, 1930

20 UNDERTAKER M W Hysong ADDRESS Wash DC



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

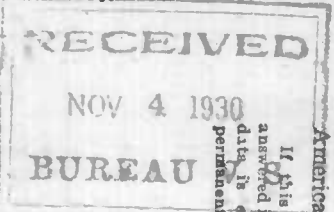
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cardiogenic fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If it is pertinent, it is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little date is essential and must be obtained before the certificate is permanently filed.



N. E.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Takoma Park, Md. Wash. D.C. & Hosp.

0558

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 223

2 FULL NAME Miss Lucy J. Arrick

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) single

6 DATE OF BIRTH January 10 1859  
(Month) (Day) (Year)

7 AGE 71 yrs. — mos. 14 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Librarian  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) St. Clairsville, Ohio.

10 NAME OF FATHER Clifford Arrick

11 BIRTHPLACE OF FATHER (State or country) St. Clairsville, Ohio

12 MAIDEN NAME OF MOTHER Margaret Josephine S. Templeton

13 BIRTHPLACE OF MOTHER (State or Country) Ohio.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanitarium Records

(Address) Takoma Park, Md.

15 Filed Jan 24 1930 H. E. Rogers  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. (Month) 24 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 22 1929 to Jan 24 1930, that I last saw her alive on Jan 22 1930, and that death occurred on the date stated above, at 8.45 a.m.  
The CAUSE OF DEATH \* was as follows:

Arteriosclerosis

Contributory (Duration) 2 yrs. 2 mos. 1 ds.  
Secondary Cerebral Hemorrhage

(Signed) Donald E. Varnum M. D.  
Jan 24 1930 (Address) Takoma Park, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 2 mos. 2 ds. In the State 2 yrs. 2 mos. 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 132 E. Capital St. D.C.

19 PLACE OF BURIAL OR REMOVAL Wash D.C. DATE OF BURIAL Jan 26, 1930

20 UNDERTAKER H. B. Davis ADDRESS 924 N. Y. Ave. NW.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 6 1930  
BUREAU V S

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Bethesda (No. \_\_\_\_\_)

2 FULL NAME Emma Jane Artz

6559

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 216

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
(Write the word)

6 DATE OF BIRTH Aug 1, 1868  
(Month) (Day) (Year)

7 AGE 68 yrs. 5 mos. 24 ds. or min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) None

9 BIRTHPLACE (State or country) Phila Pa

10 NAME OF FATHER Mr. J Stern

11 BIRTHPLACE OF FATHER (State or country) Pa

12 MAIDEN NAME OF MOTHER Elizabeth Culbertson

13 BIRTHPLACE OF MOTHER (State or country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jennie A Bogley  
(Address) Friendship Road

15 Filed Jan 25 1930 Benj. C. Perry  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 24, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 1928 to Jan 24, 1930.

that I last saw him alive on Jan 24, 1930.

and that death occurred on the date stated above, at 9:05 PM

The CAUSE OF DEATH \* was as follows:

Carcinoma of Uterus  
(Duration) 2 yrs. mos. ds.

Contributory  
Secondary

(Signed) Ben Perry M. D.  
1/25/30 (Address) Bethesda Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Lincoln Md Jan 27, 1930

20 UNDERTAKER ADDRESS

Geo W White Co Wash. DC

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia* *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melastis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Imitation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

FEB 5 1930  
BUREAU V. S.



N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Sandy Spring, Md. (No. \_\_\_\_\_)

2 FULL NAME Presley Awkward

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 217

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Unknown 1842  
(Month) (Day) (Year)

7 AGE 88 yrs. - mos. - ds. or - min.?  
If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Laborer  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland  
10 NAME OF FATHER Robert Awkward

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Scott

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elisa Hopkins  
(Address) Sandy Spring, Md.

15 Filed Mar 31 1930 C. S. Barnsley  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 29, 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 28, 1923 to March 29, 1923

that I last saw him alive on March 28, 1923

and that death occurred on the date stated above, at 3 A. m.

The CAUSE OF DEATH \* was as follows:

Inanition

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 4 ds.  
Contributory Secondary Extreme age

(Signed) C. S. Barnsley M. D.  
March 31, 1923 (Address) Sandy Spring, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Sharp Street Cemetery DATE OF BURIAL March 31, 1930

20 UNDERTAKER George Snowden ADDRESS Rockville, Md.

per issued.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business, or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 4 1930  
BUREAU

MARGIN RESERVED FOR BINDING

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Brighton (No. \_\_\_\_\_)

2 FULL NAME Baby Arkward.

0560 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 217

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE colored. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH Jan. 1, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 0 ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Brighton, Maryland

10 NAME OF FATHER George Washington Arkward

11 BIRTHPLACE OF FATHER (State or country) Montg. County

12 MAIDEN NAME OF MOTHER Evelyn W. Waters

13 BIRTHPLACE OF MOTHER (State or country) Montg. County

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo W Arkward

(Address) Brighton

15 Filed Jan. 2, 1930 Mrs C S Barnaby  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 1, 1930  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended the deceased from Jan 1, 1930 to Jan 1, 1930, that I last saw him on Jan 1, 1930

and that death occurred on the date stated above, at 8 A. m.  
The CAUSE OF DEATH \* was as follows:

Stillbirth

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) C S Barnaby M. D.  
Jan. 2, 1930 (Address) Sandy Spring, Md.

\*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Brighton Md DATE OF BURIAL Jan 2 - 1930

20 UNDERTAKER Geo W Arkward ADDRESS Brighton Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

per issued.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 4 1900

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. **AGE** should be stated **EXACTLY, PHYSICIANS** should state **CAUSE OF DEATH** in plain terms so that it may be properly classified. Exact statement of **OCCUPATION** is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Montgomery  
Waverley Sanitarium  
 Village or City Rockville (No. \_\_\_\_\_)

05682

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 213

(44)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Alessis V. Babine

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~OR DIVORCED~~  
 (Write the word)

6 DATE OF BIRTH Mar 22, 1866  
 (Month) (Day) (Year)

7 AGE 64 yrs. 1 mos. 19 ds. or min. ?  
 If LESS than 1 day... hrs.

OCCUPATION  
 (a) Trade, profession or particular kind of work... Chief of Slavic Div.  
 (b) General nature of industry, business, or establishment in which employed (or employer) Library of Congress

9 BIRTHPLACE (State or country) Elatma Russia

10 NAME OF FATHER V. P. Babine

11 BIRTHPLACE OF FATHER (State or country) Russia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Markin A. Roberts

(Address) Library of Congress D.C.

15 Filed May 10 1930 Ms. W. T. Platt  
Per. Ms. Election Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 10, 1930  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 30, 1930, to May 10, 1930.

that I last saw him alive on May 9, 1930.

and that death occurred on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH was as follows:

Carcinoma of Stomach

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Signed) Exhaustion (Duration) 1 yrs. 0 mos. 0 ds.

Robert W. Baker M.D.

May 10, 1930 (Address) 1822 Jefferson Pl.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death... yrs. 1 mos. 24 da. In the State... yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Washington, D.C.

19 PLACE OF DEATH OR REMOVAL Washington D.C. DATE OF BURIAL May 10, 1930

20 UNDERTAKER J. W. Lee & Sons ADDRESS Washington D.C.



RECEIVED

JUN 9 1930

BUREAU V. E.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Fireman*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or at *Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., or ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Montgomery

Village or City

Rockville

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

Herman J. Badenhop

Registration Dist. No. 213

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

## 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

## 6 DATE OF BIRTH

August 12, 1863

(Month)

(Day)

(Year)

## 7 AGE

67 yrs. 4 mos. 8 ds. or min.?

IF LESS than 1 day...hrs.

## 8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed or (employer)

Real Estate

## 9 BIRTHPLACE

(State or country)

Germany

## 10 NAME OF FATHER

Herman H. Badenhop

## 11 BIRTHPLACE OF FATHER

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Augusta Pilsner

## 13 BIRTHPLACE OF MOTHER

(State or Country)

Germany

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Herman J. Badenhop

(Address)

Rockville, Md.

## 15

Filed 12-21

1920 Mrs. W. T. Pratt

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Dec 20, 1920

(Month)

(Day)

(Year)

## 17 I HEREBY CERTIFY, That I attended the deceased from

Nov. 8, 1920 to December 20, 1920

that I last saw him alive on December 20, 1920,

and that death occurred on the data stated above, at 10 a. m.

The CAUSE OF DEATH \* was as follows:

Paralysis (Cerebral haemorrhage)

## Contributory Secondary

(Duration) 0 yrs. 1 mos. 12 ds.

(Duration) 1 yr. 1 mos. 12 ds.

(Signed)

H. J. Pratt

M. D.

Dec 21, 1920 (Address) Rockville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs... mos... ds.

In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Woodlawn Cemetery Dec 22, 1920

## 20 UNDERTAKER ADDRESS

Wm. Ruben Humphrey Rockville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 6 1931

BUREAU



N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Mont

01786

(129)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 213

Village or City Rockville (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Molly Baker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE cul 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH June 13, 1890  
(Month) (Day) (Year)

7 AGE 60 yrs. 8 mos. 7 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work House wife  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Henson Johnson

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Willie Johnson

13 BIRTHPLACE OF MOTHER (State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lillian Baker  
(Address) Rockville

15 Filed Feb. 23 1930 Mrs. Pratt  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 20, 1930  
(Month) Feb (Day) 20 (Year) 1930

17 I HEREBY CERTIFY, That I attended the deceased from Feb 7, 1930 to Feb 27, 1930  
that I last saw her alive on Feb 20, 1930

and that death occurred on the date stated above, at 9.20 a.m.  
The CAUSE OF DEATH \* was as follows:

Artic insufficiency

Contributory (Duration) 4 yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Secondary Chronic nephritis

(Signed) O. S. Hawks M. D.  
192 \_\_\_\_ (Address) Rockville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Rockville DATE OF BURIAL Feb. 23, 1930

20 UNDERTAKER Geo. P. Snowden ADDRESS Rockville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-alike), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 6 1930  
BUREAU

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH   |   |  | 05683 STATE OF MARYLAND<br>188-C CERTIFICATE OF DEATH |  |
|--|---|--|---|--|
| County <u>Montgomery</u>   |   |  | Registration Dist. No. <u>2/3</u>                     |  |
| Village or City <u>Westmore</u> (No. _____)  |   |  | St. _____   | Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.) |
| 2 FULL NAME <u>Alonzo Barnes</u>   |   |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |   |  |   |  |
| 3 SEX<br><u>male</u>   | 4 COLOR OR RACE<br><u>W</u>                           | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Single.</u> |   |  |
| 6 DATE OF BIRTH<br><u>Mar 10</u> , 1900<br>(Month) (Day) (Year)  |   |  |   |  |
| 7 AGE<br><u>30</u> yrs. <u>2</u> mos. <u>20</u> ds. or min.?   |   |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession or particular kind of work <u>Laborer</u><br>(b) General nature of industry business, or establishment in which employed or (employer) _____   |   |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Ind</u>   |   |  |   |  |
| PARENTS  | 10 NAME OF FATHER <u>David Barnes</u>                 |  |   |  |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u> |  |   |  |
|  | 12 MAIDEN NAME OF MOTHER <u>May Jenkins</u>           |  |   |  |
|  | 13 BIRTHPLACE OF MOTHER (State or Country) <u>Ind</u> |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE   |   |  |   |  |
| (Informant) <u>David R. Barnes</u><br>(Address) <u>West &amp; E.</u>   |   |  |   |  |
| 15 Filed <u>5-31</u> 192 <u>30</u> <u>Ms. H. T. Pratt</u><br>Registrar   |   |  |   |  |
| MEDICAL CERTIFICATE OF DEATH   |   |  |   |  |
| 16 DATE OF DEATH _____, 192 <u>30</u><br>(Month) <u>May</u> (Day) <u>30</u> (Year) <u>1930</u>   |   |  |   |  |
| 17 I HEREBY CERTIFY, That I attended the deceased from <u>May</u><br><u>Killed in auto accident</u> 192 <u>30</u><br>that I last saw him alive on _____ 192 <u>30</u><br>and that death occurred on the date stated above, at _____ m.<br>The CAUSE OF DEATH * was as follows:<br><u>Fracture of Base of Skull</u><br><u>Auto accident, between Rockville &amp; Gaithersburg,</u><br><u>Md. Car hit a culvert, throwing him out and</u><br><u>striking head on cement shoulder curb.</u><br>(Duration) _____ yrs. _____ mos. _____ ds. |   |  |   |  |
| Contributory<br>Secondary _____  |   |  |   |  |
| (Signed) <u>C. E. Hawks</u> M. D.<br><u>3/31</u> 19 <u>30</u> (Address) <u>Rockville Ind</u>   |   |  |   |  |
| *State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.  |   |  |   |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)   |   |  |   |  |
| At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.   |   |  |   |  |
| Where was disease contracted, if not at place of death? _____  |   |  |   |  |
| Former or usual residence _____  |   |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Washington, D. C.</u>  |   |  |   | DATE OF BURIAL<br><u>6-30</u> , 19 <u>30</u>   |
| 20 UNDERTAKER<br><u>Barnes &amp; Humphrey</u>  |   |  |   | ADDRESS<br><u>Rockville</u>  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architekt, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Tetanusaemum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. 3

MARGIN RESERVED FOR BINDING  
WRITE HERE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery Prince George's

12577

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 223Village or City Lakewood (No. 30)Allegheny Ave.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mary Virginia Batts BATTS

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) WIDOWED

6 DATE OF BIRTH

December 24, 1858  
(Month) (Day) (Year)

7 AGE

71 yrs. 9 mos. 17 ds. or min.?IF LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry Home maker  
business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Missouri

10 NAME OF FATHER

Norman Davis

11 BIRTHPLACE OF FATHER

(State or country)

West Virginia

12 MAIDEN NAME OF MOTHER

Margaret Austin

13 BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clarence M. Roach

(Address)

30 Allegheny Ave.  
Sakona, D.C.

15

Filed

Oct 111920Herbert J. Rogers  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct. 11, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

May 8 1930 to Oct 11, 1930that I last saw her alive on Oct 11, 1930and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH \* was as follows:

Pericarditis Aneurysmabout (Duration) 3 yrs. - mos. - ds.Contributory  
SecondaryAccident fall down steps.Contusion and shock CRO (Duration) 4 yrs. - mos. 4 ds.

(Signed)

D. B. Little

M. D.

Oct 11 1930 (Address) 6911 57 Ward se

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ... yrs. ... mos. ... ds.In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wash DCOct 14, 1930

20 UNDERTAKER

ADDRESS

S. H. Ames Co 2901-14 NW



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

under Dr. Little  
CHANGE OF COUNTY AUTHORIZED BY LETTER FILED OCT. 20 1932

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Rockville (No. R-1)

2 FULL NAME Samuel O. W. Beall

10523 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 2/3

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Sept 21, 1855  
(Month) (Day) (Year)

7 AGE 75 yrs. — moa. — ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Paper hanger  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country) md

10 NAME OF FATHER Wm Beall

11 BIRTHPLACE OF FATHER  
(State or country) md

12 MAIDEN NAME OF MOTHER Annie Linthicum

13 BIRTHPLACE OF MOTHER  
(State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. T. Foster

(Address) Rockville - md

15 Filed 9-24 1930 Mrs. W. T. Pratt  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 21, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 1929 to Sept 21, 1930, that I last saw him alive on Sept 20, 1930,

and that death occurred on the date stated above, at 9:00 P.M.  
The CAUSE OF DEATH \* was as follows:

Acute Cardiac dilatation

(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Contributory Chronic Valvular heart disease  
Secondary

(Duration) 1 yrs. 2 mos. \_\_\_ ds.

(Signed) E. T. Foster M. D.

9-24-30 (Address) Rockville - md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients & Recent Residents)

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Rockville Union bury DATE OF BURIAL Sept 24, 1930

20 UNPERTAKEN

W. R. Humphrey ADDRESS Rockville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

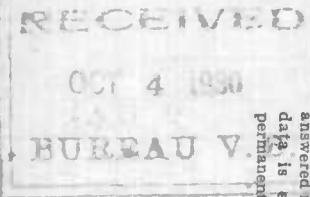
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anæmia;" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

*Montgomery*

04434

(90)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *211*Village or City *nr. Lewisdale* (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Sally E. Beall*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.* 4 COLOR OR RACE *W.* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*  
(Write the word)

6 DATE OF BIRTH

*June 11 1857*  
(Month) (Day) Year

7 AGE

*72* yrs. *10* mos. *14* ds. or min. 2If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Housework*

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(-state or country)

*Maryland*

10 NAME OF FATHER

*Gabriel Lewis D. Lawson*

11 BIRTHPLACE OF FATHER

(State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Leannette Moxley*

13 BIRTHPLACE OF MOTHER

(State or country)

*Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Eronin Beall*

(Address)

*P. D. Blacksburg*

15

Filed *April 27 1930* *Della H. Beall*  
Registral

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*April 25 1930*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from *April 25 1930* to *April 25 1930*, that I last saw her *dead* on *April 25 1930*, and that death occurred on the date stated above, at *10:15* a.m.

The CAUSE OF DEATH was as follows:

*Probably - Acute Dilatation of the heart.*Contributory  
Secondary(Duration) *A few minutes*  
yrs. mos. ds.(Signed) *George M. Boyer* M. D.*Apr. 26 1930* (Address) *Damascus, Md*

\*State the Cause of Death, or, in deaths from Violent Causes, state (1) Mode of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Bethesda Cemetery*  
*Brownsville, Md.**Apr. 27 1930*

20 UNDERTAKER

ADDRESS

*J. B. Beall, Inc. Damascus, Md.*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 6 1930



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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<sup>1</sup> PLACE OF DEATH  
County Montgomery

12540

(188-C)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 2/2

Village or City Providence (No.     )

St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Wm H Beaudry (BEANDER)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH      (Month)      (Day)      (Year)

7 AGE about 19 yrs.      mos.      ds. or min. If LESS than 1 day      hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Team Driver (b) General nature of industry, business, or establishment in which employed or (employer)     

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Wm Beaudry (Beaudry)

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Beaudry

13 BIRTHPLACE OF MOTHER (State or country) Beaudry

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm H Beaudry

(Address) Providence

15 Filed Oct 6 1930 E. W. H. Beaudry Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 5 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from      to     , 192    

that I last saw him alive on     , 192    

and that death occurred on the date stated above, at about 9 P. M.

The CAUSE OF DEATH \* was as follows:

Automobile turned over on him caused immediate death.

(Accidental) (Duration)      yrs.      mos.      ds.

Contributory Automobile accident Secondary

(Duration)      yrs.      mos.      ds.

(Signed) E. W. H. Beaudry M. D.

192     (Address)     

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death      yrs.      mos.      ds. In the State      yrs.      mos.      ds.

Where was disease contracted, if not at place of death?

Former or usual residence     

19 PLACE OF BURIAL OR REMOVAL Sugarland

DATE OF BURIAL Oct 7 1930

20 UNDERTAKER Wm H Beaudry & Son

ADDRESS Providence

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucositis; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 3 1930  
BUREAU V. S.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Montgomery

08132

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 223Village or City Takoma Park (No. Md. Washington Sanitarium Hosp<sup>304</sup>)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mr. Joseph Beetham

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE American White 5 SINGLE, ~~MARRIED~~ married  
WIDOWED.  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH September 1867  
July 22 1930  
(Month) (Day) (Year)

7 AGE 62 yrs. 10 mos. unknown IF LESS than  
1 day, hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Supervisor  
(b) General nature of industry, business, or establishment in which employed or (employer) Telephone Co.

9 BIRTHPLACE (State or country) Bay City, Michigan

10 NAME OF FATHER William H. Beetham

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Rose Donnelly

13 BIRTHPLACE OF MOTHER (State or country) Michigan

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanitarium Records  
(Address) Takoma Park Md

15 Filed July 22 1930 H. E. Rogers  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 22, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from  
June 13, 1930 to July 22, 1930,  
that I last saw him alive on July 22, 1930,

and that death occurred on the date stated above, at 12:55 noon

The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage(Duration) 1 mos. 9 ds.Contributory  
SecondaryHypertension(Duration) Unknown mos. ds.(Signed) Donald C. Nelson M. D.July 22, 1930 (Address) Wash. San + Hosp.

\*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 1 mos. 9 ds. In the State 0 yrs. 1 mos. 9 ds.

Where was disease contracted, if not at place of death? Washington D.C.Former or usual residence 5610 14th St. N.W. Washington D.C.

19 PLACE OF BURIAL OR REMOVAL

Wash. D.C.

DATE OF BURIAL

July 22, 1930

20 UNDERTAKER

The S. H. Hines Co. Wash. D.C.

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

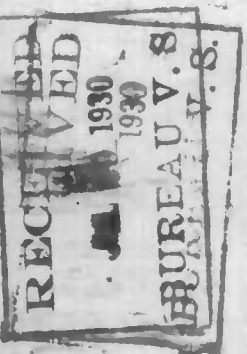
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mastitis* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—acidul; Reacher wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A. The data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County MontgomeryVillage or City Glen Echo Hgts. (No. \_\_\_\_\_)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 11-a

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Joseph Dale Beighey

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)6 DATE OF BIRTH Nov. 1<sup>st</sup>, 1930  
(Month) (Day) (Year)7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 1 ds. or \_\_\_\_\_ min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work \_\_\_\_\_

(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or Country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frances Beighey(Address) Glen Echo Hgts. Md.15 Filed Nov. 2 30 1930 W. H. Sando & Co Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 2<sup>nd</sup>, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Nov. 1<sup>st</sup>, 1930 to Nov. 2<sup>nd</sup>, 1930  
that I last saw him alive on Nov. 1<sup>st</sup>, 1930and that death occurred on the date stated above, nt 6<sup>30</sup>a. m.  
The CAUSE OF DEATH \* was as follows:Premature birth.Contributory  
Secondary(Signed) E. G. Bauer M. D.  
Nov. 2, 1930 (Address) Bethesda Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

Washington D.C.

## DATE OF BURIAL

Nov. 5, 1930

## 20 UNDERTAKER

W. H. Sando & Co

## ADDRESS

Wash. D.C.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashtenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as *fracture of skull*, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

RECEIVED  
NOV 8 1920

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Laytonsville (No. \_\_\_\_\_)

2 FULL NAME Hella H. Bell

6561 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 216

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Whit. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH May 28 1861  
(Month) (Day) (Year)

7 AGE 68 yrs. 8 mos. 1 ds. or LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work At home  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER G. H. Warfield

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Lewis

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Bell

(Address) Laytonsville

15 Filed Jan 30 1930 Bachelman & Tamm  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 29 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 23 1930 to Jan 29 1930, that I last saw her alive on Jan 29 1930, and that death occurred on the date stated above, at 2:00 P. m.  
The CAUSE OF DEATH \* was as follows:

Cerebral hemorrhage

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 5 ds.  
Contributory hypertension  
Secondary

(Duration) 8 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. J. Brochert M. D.  
1-30 1930 (Address) Eximberburg, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 5 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State 68 yrs. 8 mos. 1 ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence Same

19 PLACE OF BURIAL OR REMOVAL Laytonsville DATE OF BURIAL Jan 31 1930

20 UNDERTAKER Rog H. Barber ADDRESS Laytonsville Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

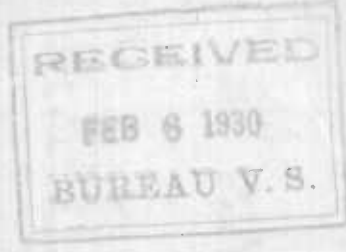
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Pneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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PLACE OF DEATH  
County Montgomery

Village or City Rockville (No. \_\_\_\_\_)

FULL NAME Glendora Bell

03088 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Feb 9, 1914  
(Month) (Day) (Year)

7 AGE 16 yrs. 0 mos. 24 ds. or min.?  
IF LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Schoolgirl  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Martinsburg, Md.

10 NAME OF FATHER Isaiah Bell

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Glarence Brunner

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maurice Bell  
(Address) Rockville, Md.

15 Filed 3-8 1930 Mrs. W. T. Pratt  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 5 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 21 1930 to March 5, 1930  
that I last saw her alive on March 4, 1930  
and that death occurred on the date stated above, at 10 P. m.  
The CAUSE OF DEATH \* was as follows:

Bronchopneumonia with symptoms suggesting  
meningitis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.

Contributory Pertussis  
Secondary  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. about 21 ds.

(Signed) W. A. Lathrop M. D.  
Mar 6 1930 (Address) Rockville, Md.

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Martinsburg, Md. DATE OF BURIAL March 9, 1930

20 UNDERTAKER Warner E. Pumphrey ADDRESS Rockville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugstion, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Œmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL, peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
APR 7 1930  
BUREAU



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County MontgomeryVillage or City New Laytonville Md2 FULL NAME Myron L Bennett

08133

(188-d)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 218

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

|                      |                                 |  |
|----------------------|---------------------------------|--|
| 3 SEX<br><u>Male</u> | 4 COLOR OR RACE<br><u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)<br><u>Married</u> |
|----------------------|---------------------------------|--|

6 DATE OF BIRTH

Unknown Unknown 1901  
(Month) (Day) (Year)

7 AGE

29 yrs. 0 mos. 0 ds. or 0 min.?If LESS than  
1 day \_\_\_\_ hrs.  
or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Mechanic

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Mass

10 NAME OF FATHER

Charles A Bennett

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Elizabeth Hines

13 BIRTHPLACE OF MOTHER

(State or Country)

Nova Scotia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mildred Bennett

(Address)

New Haven Conn

15

Filed July 11 1930 V H Dixon  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 10, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Death suddenly from Crash, 1930,  
that I last saw him alive on July 10, 1930,  
and that death occurred on the date stated above, at 4:40 p.m.

The CAUSE OF DEATH \* was as follows:

Cerebral Contusion and  
Hemorrhage Caused by fall  
in Penitentiary Accompanying  
Sudden Death  
(Duration) 0 yrs. 0 mos. 0 ds.Contributory  
Secondary(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

Vernon H Dixon M. D.  
July 11, 1930 (Address) New Laytonville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds.In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Haven Conn July 13, 1930

20 UNDERTAKER

ADDRESS

Roy W Barber Guthrie

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Echausion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery, Md

12539

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City Takoma Park. (No. 821 Flower St.) (Ward     ) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Benson, Mr Charles Edward

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) MARRIED ✓

6 DATE OF BIRTH Oct 30 1956  
(Month) (Day) (Year)

7 AGE 73 yrs. 11 mos.      ds. or      min. IF LESS than 1 day      hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work None. (b) General nature of industry business, or establishment in which employed or (employer)     

9 BIRTHPLACE (State or country) Del.

10 NAME OF FATHER Joseph Benson

11 BIRTHPLACE OF FATHER (State or country) Del.

12 MAIDEN NAME OF MOTHER un known

13 BIRTHPLACE OF MOTHER (State or country)     

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Fern B. Jacques  
(Address) 821 Flower St. Takoma Park, Md

15 Filed Oct 30 1930 H. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 30 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 26 1930 to Oct 30 1930 that I last saw him alive on Oct 27 1930 and that death occurred on the date stated above, at 7:45 A. M.

The CAUSE OF DEATH \* was as follows:

Carcinoma of Pancreas

(Duration) un known ds. Contributory Arteriosclerosis Secondary Ch. Degenerative Myocarditis (Duration)      yrs.      mos.      ds.

(Signed) H. T. Moore M. D. Oct 30 1930 (Address) Wash. San. Takoma Park, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death      yrs.      mos.      ds. In the State      yrs.      mos.      ds.

Where was disease contracted, if not at place of death?

Former or usual residence     

19 PLACE OF BURIAL OR REMOVAL H. Lincoln Crematory DATE OF BURIAL Nov 1 1930

20 UNDERTAKER H. B. Nevins ADDRESS 924 N. J. Ave. N.W.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Creeping Typhoid fever" never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Broncho pneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mexles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by running train—accident*; *River boat wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAY 4 1930  
BUREAU

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County

MontgomerySTATE OF MARYLAND  
CERTIFICATE OF DEATH

04435

Registration Dist. No. 218Village or City Washington (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John E. Benson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Married

6 DATE OF BIRTH

Mar 5, 1848  
(Month) (Day) (Year)

7 AGE

85 yrs. 1 mos. 5 ds. or min.?If LESS than  
1 day \_\_\_\_ hrs.  
1 day \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)Maryland10 NAME OF  
FATHERWilliam H. Benson11 BIRTHPLACE  
OF FATHER  
(State or country)Maryland12 MAIDEN NAME  
OF MOTHERJames Trail13 BIRTHPLACE  
OF MOTHER  
(State or Country)Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Maggie Benson

(Address)

Gaithersburg Md

15

Filed Apr 22, 1930 V. H. Dyson  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 20, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from  
April 13<sup>th</sup>, 1930 to Apr 20, 1930.that I last saw him alive on April 20, 1930,and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH \* was as follows:

Lobar PneumoniaContributory  
Secondary(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 7 ds.(Signed) V. H. Dyson M. D.Apr 21, 1930 (Address) Laytonville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Frederickville MdApr 23, 1930

20 UNDERTAKER

Roy W. Barker

ADDRESS

Gaithersburg

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 6 1930

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|   |                             |  |   |  |  |   |  |  |
|---|-----------------------------|--|---|--|--|---|--|--|
| 1 PLACE OF DEATH<br><i>Montgomery</i>   |                             |  | 08507   |  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |  |  |
| County <i>Silver Spring</i>   |                             |  | 740   |  |  | Registration Dist. No. <i>214</i>         |  |  |
| Village or City <i>Washington</i>   |                             |  | (No. <i>740</i> )   |  |  | Ward <i>St. Ann</i>                       |  |  |
| 2 FULL NAME<br><i>John Best</i>   |                             |  | (If death occurred in a hospital or institution, give its NAME instead of street and number.)   |  |  |   |  |  |
| PERSONAL AND STATISTICAL PARTICULARS  |                             |  |   |  |  |   |  |  |
| 3 SEX<br><i>M</i>   | 4 COLOR OR RACE<br><i>W</i> | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED<br>(Write the word)<br><i>Widower</i> | 16 DATE OF DEATH<br><i>July 23, 1930</i><br>(Month) (Day) (Year)  |  |  |   |  |  |
| 6 DATE OF BIRTH<br><i>Apr. 9, 1857</i><br>(Month) (Day) (Year)  |                             |  | 17 I HEREBY CERTIFY, That I attended the deceased from <i>July 18, 1930</i> to <i>July 23, 1930</i><br>that I last saw him alive on <i>July 22, 1930</i>                              |  |  |   |  |  |
| 7 AGE<br><i>73</i> yrs. <i>3</i> mos. <i>13</i> ds.   |                             |  | If LESS than 1 day, hrs. or min.?<br>and that death occurred on the date stated above, at <i>3</i> m.<br>The CAUSE OF DEATH * was as follows:<br><i>Cerebral Hemorrhage</i>           |  |  |   |  |  |
| 8 OCCUPATION<br>(a) Trade, profession or particular kind of work<br>(b) General nature of industry, business, or establishment in which employed or (employer)<br><i>None</i> |                             |  | Duration <i>3</i> mos. <i>3</i> ds.   |  |  |   |  |  |
| 9 BIRTHPLACE<br>(State or country)<br><i>Md.</i>  |                             |  | Contributory Secondary<br><i>Arteriosclerosis</i>   |  |  |   |  |  |
| 10 NAME OF FATHER<br><i>John Best</i>   |                             |  | (Signed) <i>John Best</i>   |  |  |   |  |  |
| 11 BIRTHPLACE OF FATHER<br>(State or country)<br><i>Md.</i>   |                             |  | (Address) <i>Plawright</i>  |  |  |   |  |  |
| 12 MAIDEN NAME OF MOTHER<br><i>Margaret Harman</i>  |                             |  | *State the Cause Causing Death, or, in deaths from violent causes, state (1) Means of injury and (2) Whether accidental, suicidal or homicidal.                                       |  |  |   |  |  |
| 13 BIRTHPLACE OF MOTHER<br>(State or Country)<br><i>Md.</i>   |                             |  | LENGTH OF RESIDENCE (For Hospitals, Institutions, Tr. or other Recent Residents)<br>At place of death <i>4</i> yrs. <i>25</i> mos. <i>25</i> ds. In the State <i>DC</i> yrs. mos. ds. |  |  |   |  |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <i>Mrs. Clara Best</i><br>(Address) <i>Silver Spring</i>  |                             |  | Where was disease contracted, if not at place of death?<br>Former or usual residence <i>DC</i>  |  |  |   |  |  |
| 15 Filed <i>July 23, 1930</i>   |                             |  | 19 PLACE OF BURIAL OR REMOVAL<br><i>Rockville Md.</i>   |  |  | DATE OF BURIAL<br><i>July 25, 1930</i>    |  |  |
| 16 REGISTRAR<br><i>J. E. Blodgett</i>   |                             |  | 20 UNDERTAKER<br><i>W. R. Murphy</i>  |  |  | ADDRESS<br><i>Rockville</i>               |  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationery fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
SEP 6 1930  
BUREAU

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Lilox Spring, Md (No. 74a)

01787

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

St. Maplewood Sen Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Tyrinal Edward Biddle

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH ? ? 1845  
(Month) (Day) (Year)

7 AGE 84 ? ? ?  
yrs. mos. ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Clerk  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) England.

10 NAME OF FATHER Richard Biddle

11 BIRTHPLACE OF FATHER (State or country) England.

12 MAIDEN NAME OF MOTHER Charlotte Dequentele

13 BIRTHPLACE OF MOTHER (State or Country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Lucian Hawland  
(Address) Lilox Spring, Md.

15 Filed Feb 21 1930 J. E. Windley Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 21, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 15 1929 to Feb. 21, 1930  
that I last saw him alive on Feb. 21, 1930

and that death occurred on the date stated above, at 5:45 p.m.  
The CAUSE OF DEATH \* was as follows:

Ruptured Aortic Aneurysm

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory Secondary Arteriosclerosis

(Duration) 4 yrs. 0 mos. 0 ds.

(Signed) Wm. H. Hays M. D.  
Feb. 21 1930 (Address) Lilox Spring, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 7 mos. 7 ds. In the State 2 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence DC

19 PLACE OF BURIAL OR REMOVAL Washington DC

DATE OF BURIAL Feb 24 1930

20 UNDERTAKER Martina H. Thompson  
1300 N. 1st St  
Wash DC

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Montgomery

0562

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City

New Berlin Naverley Sanatorium

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Florence V. Blue

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Widowed

6 DATE OF BIRTH

January 1, 1863

(Month) (Day) (Year)

7 AGE

67 yrs. 0 mos. 28 ds.

If LESS than  
1 day.....hrs.  
or.....min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Ga.

10 NAME OF

FATHER

Geo. Freyboth

11 BIRTHPLACE

OF FATHER

(State or country)

Ga.

12 MAIDEN NAME

OF MOTHER

Emma Fairfax

13 BIRTHPLACE

OF MOTHER

(State or Country)

Ga.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. C. S. Nash

(Address)

1734 Dist NW

15

Filed

1-30-

1920

Mrs. H. T. Pratt

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 29, 1930

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

January 2, 1930, to January 29, 1930, that I last saw her alive on January 28, 1930,

and that death occurred on the date stated above, at 1:45 A.M.

The CAUSE OF DEATH \* was as follows:

Cerebral thrombosis  
arteriosclerosis

(Duration) yrs. mos. 26 ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Delbert E. E. E. E. E. M. D.

Jan. 29, 1930. (Address) The Rock Creek S.C., Washington, D.C.

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. 16 ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Penna.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rock Creek S.C., Jan. 30, 1930

20 UNDERTAKER

ADDRESS

Harold Campbell Rockville

If more blanks are needed, address State Registrar, 16 W. Seneca St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Assthemia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
FEB 6 1910  
BUREAU

12/10 1909 D. G. Wood of m. m.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Montgomery

Village or City Lakoma Park (No. Wash San & Hospital)

<sup>2</sup> FULL NAME unnamed

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 223

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) \_\_\_\_\_  
6 DATE OF BIRTH April 2<sup>nd</sup>, 1930  
(Month) (Day) (Year)  
7 AGE \_\_\_\_\_ If LESS than 1 day, hrs. \_\_\_\_\_  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER L Stewart-Bolton  
11 BIRTHPLACE OF FATHER (State or country) md  
12 MAIDEN NAME OF MOTHER Margaret King  
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records  
(Address) Wash San & Hosp

15 Filed April 2 1930 H. E. Rogers  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 2<sup>nd</sup>, 1930  
(Month) (Day) (Year)  
17 I HEREBY CERTIFY, That I attended the deceased from April 2<sup>nd</sup>, 1930 to April 2<sup>nd</sup>, 1930, that I last saw him alive on April 2<sup>nd</sup>, 1930, and that death occurred on the date stated above, at 7:30 m.

The CAUSE OF DEATH \* was as follows:  
Premature birth - Premature separation of Placenta  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory Toxic Osmosis  
Secondary \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Lauretta E. Kress M. D.  
April 2 1930 (Address) Lakoma Park Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Cedar Hill DATE OF BURIAL 4/2, 1930

20 UNDERTAKER H. B. Nevius ADDRESS 924 N. York Ave

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., etc. . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 8 1930

DEPT. OF HEALTH

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Montgomery

01788

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 2/3Village or City Potomac (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Infant Bolton

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Feb. 5, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day 0 hrs. \_\_\_\_\_  
yrs. 15 minutes or 15 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Potomac, Maryland

10 NAME OF FATHER Lewis E. Bolton

11 BIRTHPLACE OF FATHER (State or country) Montg. Co., Md.

12 MAIDEN NAME OF MOTHER Lillian M. Frazer

13 BIRTHPLACE OF MOTHER (State or Country) Calhoun, Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis E. Bolton(Address) Potomac, Md. Rockville

15 Filed 2/7 1930 Mrs. W. T. O'Neil  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH \_\_\_\_\_, 1930  
Feb. (Month) 5 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb. 5, 1930 to Feb. 5, 1930.

that I last saw him alive on Feb. 5, 1930.

and that death occurred on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH \* was as follows:

Prematurity  
(Twin - 7 months)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Secondary None

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. R. Luthicund M. D.

Feb. 5, 1930 (Address) Rockville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Potomac DATE OF BURIAL 2/7, 1930

20 UNDERTAKER W. R. Pumphrey Jr. ADDRESS Rockville



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, "PUERPERAL peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Montgomery*

Village or City

*Potomac*

(No. \_\_\_\_\_)

## 2 FULL NAME

*Infant Bolton*STATE OF MARYLAND  
CERTIFICATE OF DEATH

01789

(16-a)

Registration Dist. No.

*213*

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*Single*

6 DATE OF BIRTH

*Feb. 5, 1930*  
(Month) (Day) (Year)

7 AGE

\_\_\_\_ yrs. \_\_\_\_ mos. *0* da. or \_\_\_\_ min.?If LESS than 1 day *8* hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

*None*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Potomac, Md.*

10 NAME OF FATHER

*Levis E. Bolton*

11 BIRTHPLACE OF FATHER

(State or country)

*Montg. Co., Md.*

12 MAIDEN NAME OF MOTHER

*Sullivan M. Thayer*

13 BIRTHPLACE OF MOTHER

(State or Country)

*Culpepper, Va.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Levis E. Bolton*

(Address)

*Potomac, Md (Rockville, Md)*

15

Filed *2-7*

1930

*Mrs. H. T. Crail*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Feb. 5, 1930*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

*Feb. 5, 1930* to *Feb. 5, 1930*that I last saw him alive on *Feb. 5, 1930*and that death occurred on the date stated above, at *10 P. m.*

The CAUSE OF DEATH \* was as follows:

*Prematurity (Living 7 months)*

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary*None*

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) *Wm. A. Luthers* M. D.*Feb. 6, 1930* (Address) *Rockville, Md.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Potomac**2/7, 1930*

20 UNDERTAKER

ADDRESS

*W. R. Humphrey Jr. Rockville*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Ehaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, "PUERPERAL peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 8 1901  
BUREAU V. B.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Mont

08134

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City Olney

(No. Mont Co Gen Hosp)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Bowie

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE Cal 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH July 3 - 1930  
(Month) (Day) (Year)

7 AGE — yrs. — mos. — ds. or — min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER John Bowie

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Thomas

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Bowie

(Address) Brookville Md

15 Filed July 4 1930 C. J. Barnsley  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 3 - 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 3 1930 to July 3 1930  
that I last saw her er still on July 3 1930

and that death occurred on the date stated above, at 2 P. m.  
The CAUSE OF DEATH \* was as follows:

Stillbirth

Contributory  
Secondary

(Signed) C. S. Ambleson M. D.  
July 3 1930 (Address) Sandy Spring Md  
State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the 0 yrs. 0 mos. 0 ds.  
State

Where was disease contracted, if not at place of death? home

Former or usual residence Brookville Md

19 PLACE OF BURIAL OR REMOVAL Sandy Spring DATE OF BURIAL July 4 1930

20 UNDERTAKER John Bowie ADDRESS Brookville Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

for issued

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesenteric whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL pyelitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 4 1900  
BUREAU V. S.



MARGIN RESERVED FOR BINDING

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Village or City

(No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Nov 28 1930 CS 3 amalay

Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 217

13907

(183)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

11 - 27 - 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 11/27/1930 to 11/27/1930,

that I last saw him alive on 11/26/1930

and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH \* was as follows:

Gun shot wound of right arm + forearm, accidental

(Duration) yrs. mos. 7 ds.

Contributory Secondary

Bacterial Septicemia

(Duration) yrs. mos. 5 ds.

(Signed)

11/28/1930 Address Sandy Sp

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pinney Grove Nov 29 1930

20 UNDERTAKER

ADDRESS

E. C. Galtner Gaithersburg

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 3 1930

BUREAU V. S.

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1 PLACE OF DEATH  
County Montgomery

06815

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 211Village or City W. Woodfield (No. 124)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Melissa Tandrige Bowman

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH April 6, 1844  
(Month) (Day) Year

7 AGE 86 yrs. 1 mos. 25 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Upton Riggs

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Keziah Purdum

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Upton Bowman(Address) Germanstown, Md.

15 Filed June 3, 1930 Della W. Beall  
Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 1, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 26, 1930 to June 1, 1930, that I last saw her alive on May 31, 1930.

and that death occurred on the date stated above, at 12:30 p. m.

The CAUSE OF DEATH \* was as follows:

Cholecystitis(Duration) yrs. mos. 7 ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) George M. Boyer M. D.June 1, 1930 (Address) Damascus, Md.

\*State the Cause Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Upper Seneca Baptist Cemetery, June 4, 193020 UNDERTAKER J. B. Beall, Inc. ADDRESS Damascus, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE ONLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

*Montgomery*

Village or City

*Frost Glen*

(No.

05684

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

*214*

2 FULL NAME

*Miss Eulalie Braddock*

If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*White*

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

*Single*

6 DATE OF BIRTH

*June 26, 1852*  
(Month) (Day) (Year)

7 AGE

*77 yrs. 10 mos. 21 ds.* or min. ?

If LESS than 1 day....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed or (employer)*None*

9 BIRTHPLACE

(State or country)

*Rockville, Md*

10 NAME OF FATHER

*Mr George K. Braddock*

11 BIRTHPLACE OF FATHER

(State or country)

*Rockville, Md*

12 MAIDEN NAME OF MOTHER

*Jabitha Austin*

13 BIRTHPLACE OF MOTHER

(State or country)

*Montgomery Co Md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mrs Blanche Cramer*

(Address)

*Shenandoah, Frost Glen, Md*

15

Filed

*May 18 1930*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*May 17, 1930*  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*After death which was*that I last saw him alive on *sudden*, 192and that death occurred on the date stated above, at *12 noon* m.

The CAUSE OF DEATH was as follows:

*Apoplexy*

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

*Marion Bant head* M. D.*May 17 1930* (Address) *Shenandoah, Md*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. da.

In the State, yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Rockville Union Cemetery May 19 1930*

20 UNDERTAKER

ADDRESS

*L.O.P. Humphrey Jr. Rockville Md.*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Team laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *House wife*, *Housewife*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If relieved from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the disease CAUSING DEATH (the primary affection), with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Typhoid"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Meninges*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Frontopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Constitutional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from edematous or miscarrhæmic as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Retention wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (All commendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is to be filed over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data essential and must be obtained before the certificate is permanently filed.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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PLACE OF DEATH

County

Village or City

(No. \_\_\_\_\_)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 216

 St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed  
 (Write the word)

6 DATE OF BIRTH

January 13, 1860  
 (Month) (Day) (Year)

7 AGE

70 yrs. 4 mos. 17 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.

8 OCCUPATION

 (a) Trade, profession or particular kind of work  
 (b) General nature of industry business, or establishment in which employed or (employer)
Housekeeper

9 BIRTHPLACE

(State or country)

Moutg Co. Md

10 NAME OF FATHER

Joseph A. Blundey

11 BIRTHPLACE OF FATHER

(State or country)

Fairfax - Va.

12 MAIDEN NAME OF MOTHER

Ann Minnie Wilson

13 BIRTHPLACE OF MOTHER

(State or Country)

Washington D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Edna V. Bran  
Bethesda Md.

15

Filed

June 15 1930 Benj. C. Perry  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 31st, 1930  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Jan 1930 to May 31st, 1930,  
 that I last saw him alive on May 31st, 1930,

 and that death occurred on the date stated above, at 12:05 A.M.  
 The CAUSE OF DEATH \* was as follows:

Heart failure  
myocarditis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.

June 1, 1930. (Address) Bethesda

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Zion Cem. Md June 2, 1930

20 UNDERTAKER

ADDRESS

W. R. Humphrey & Co. Rockville Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 5 1930  
HOSPITAL

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Lanham (No. 2)

2 FULL NAME Still Birth (Braunson)

08135 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE Col. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH 7-4-1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min. If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Lanham, Md.

PARENTS  
10 NAME OF FATHER James Braunson  
11 BIRTHPLACE OF FATHER (State or country) Md.  
12 MAIDEN NAME OF MOTHER Jene Coates  
13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jene Coates  
(Address) Lanham, Md. R. 2

15 Filed 7/4 1930 W. J. Braunson Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7-4-1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 7-4-1930 to 7-4-1930, that I last saw her alive on 7-4-1930, and that death occurred on the date stated above, at 1 A m.

The CAUSE OF DEATH \* was as follows:

Still Birth  
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Signed) W. C. Miller M. D.  
7-4-1930 (Address) Gaithersburg, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL at home DATE OF BURIAL 7-4-1930

20 UNDERTAKER James Braunson ADDRESS Lanham, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archivist, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mexles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A check is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
AUG 6 1930  
BUREAU



WRITE PROMPTLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery Co.

Village or City Washington Sanatorium (If death occurred in a hospital or institution, give its NAME instead of street and number)

09372 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 223

2 FULL NAME Infant of John and Blanche Brennan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE American 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Aug 11, 1930  
(Month) (Day) (Year)

7 AGE 8 yrs. 2 mos. 0 ds. or 1 day 0 hrs. 0 min. If LESS than 1 day, 0 hrs. 0 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work D  
(b) General nature of industry, business, or establishment in which employed or (employer) D

9 BIRTHPLACE (State or country) Washington Sanatorium

10 NAME OF FATHER John F. Brennan

11 BIRTHPLACE OF FATHER (State or country) H. C. Wash.

12 MAIDEN NAME OF MOTHER Blanche Kelly

13 BIRTHPLACE OF MOTHER (State or country) Wash D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Max B. Estel

(Address) Washington Sanatorium

15 Filed Aug 11, 1930 H. E. Rogers Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 11, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 11, 1930 to Aug 11, 1930, that I last saw him not on Aug 11, 1930, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH \* was as follows:

Stomach

Contributory  
Secondary

Stomach (Duration) 1 yrs. 0 mos. 0 ds.

(Signed) Eugene J. Rogers M. D.  
Aug 11, 1930 (Address) Washington Sanatorium

\* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Wash D.C. DATE OF BURIAL Aug. 11, 1930

20 UNDERTAKER H. F. Costello ADDRESS Wash D.C.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *metastases*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—decident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few data is essential and must be obtained before the certificate is permanently filed.

No. 3. Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery  
Village or City Lebanon (No. 90)

09720

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 214Village or City Lebanon (No. 90)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Edith M. Breunen

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed  
6 DATE OF BIRTH March 24, 1876  
Aug. 30, 1930  
(Month) (Day) (Year)

7 AGE 48 yrs. 5 mos. 6 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ① Emelia Boberg(Address) 4109 Harrison St. N.W. Wash. D.C.

15 Filed Sept. 1, 1930 J.E. Wadley  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug. 30, 1930 to Aug. 30, 1930, that I last saw him dead on Aug. 30, 1930, and that death occurred on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH \* was as follows:  
Chronic valvular heart disease

(Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Signed) Wheeler J. Huff M. D.  
Aug. 31, 1930 (Address) Bethesda, Md.

\* State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cedar Hill Cemetery Sept. 3, 1930

20 UNDERTAKER ADDRESS

Martin M. Hyson & Co. 1300 N. N.W.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Printer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (c) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis*, etc., *Carcinoma, Sarcoma*, etc., of . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease cause death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (mere symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of Information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery Co.

Village or City Washington (No. 1)

2 FULL NAME Ila White Bauer

08136

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 212

St. 1 Ward 1 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH July 28, 1952  
(Month) (Day) (Year)

7 AGE 78 yrs. 0 mos. 27 ds. or min.?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work House wife  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Montgomery Co. Maryland

10 NAME OF FATHER Benjamin Stephen White

11 BIRTHPLACE OF FATHER (State or country) Montgomery Co. Maryland

12 MAIDEN NAME OF MOTHER Sarah Ellen Nichols

13 BIRTHPLACE OF MOTHER (State or Country) Montgomery Co. Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rutha Pinwell Bauer

(Address) Montgomery Co. Maryland

15 Filed July 29 1930 E. W. White  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 1 1930 to July 29, 1930  
that I last saw her alive on July 28, 1930

and that death occurred on the date stated above, at 11 m.  
The CAUSE OF DEATH\* was as follows:

Arthritis Chronic  
(Anorexia Nervosa)  
3 years

(Duration) 30 yrs. 0 mos. 0 ds.

Contributory Acute Myocarditis  
Secondary

(Duration) 5 yrs. 0 mos. 0 ds.

(Signed) E. W. White M. D.

July 29 1930 (Address) Poolsville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Beallsville DATE OF BURIAL July 30, 1930

20 UNDERTAKER Hilton & Hall ADDRESS Poolsville



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 5 1930

BUR

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Montgomery

05685

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 214Village or City Fairland (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME, its stand of street and number.)

2 FULL NAME John M. Brian

## PERSONAL AND STATISTICAL PARTICULARS

|                      |                                 |   |
|----------------------|---------------------------------|---|
| 3 SEX<br><u>male</u> | 4 COLOR OR RACE<br><u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>single</u> |
|----------------------|---------------------------------|---|

6 DATE OF BIRTH September 9, 1880  
(Month) (Day) (Year)7 AGE 66 yrs. 7 mos. 20 ds. or 20 min.?  
If LESS than 1 day \_\_\_\_ hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER John M. Brian11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Margaret Whitmore13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. F. Brian(Address) Beltville, Md. R. F. D.15 Filed May 5 1930 J. E. Hudley Registrar  
Deputy

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 4, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from May 1, 1930 to May 4, 1930  
that I last saw him alive on May 3, 1930  
and that death occurred on the date stated above, at 12:05 A. M.  
The CAUSE OF DEATH was as follows:Acute dilatation of heartContributory Lobar Pneumonia  
Secondary of lung lower and middle lobes involved  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 1 ds.(Signed) M. D.  
May 5, 1930 (Address) Fairland, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Mark's Cemetery, Fairland May 6, 1930

20 UNDERTAKER ADDRESS

Warner E. Humphrey Rockville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Broncho pneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 7 1930

BUREAU OF

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

(129)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City Olney (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Michael E. Brian

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 12/7/1900  
(Month) (Day) (Year)

7 AGE 30 yrs. 18 mos. 21 ds. or min. If LESS than 1 day hrs.

## OCCUPATION

(a) Trade, profession or particular kind of work Government Clerk.  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER John Shirley

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Hilda Aderson

13 BIRTHPLACE OF MOTHER (State or Country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. J. Shirley

(Address) Elmhurst Ind.

15 Filed Dec 28 1930 C. B. Barnes Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12/28/1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 10/1/1930 to 12/29/1930

that I last saw him alive on 12/29/1930

and that death occurred on the date stated above, at 10 P m.

The CAUSE OF DEATH \* was as follows:

Chronic Interstitial Nephritis

(Duration) 4 yrs. 1 mos. 1 ds.  
Contributory Cerebral Hemorrhage  
Secondary (Duration) 1 yrs. 1 mos. 1 ds.

(Signed) J. M. W. M. D.

12/29/1930 (Address) Sandy Spring Ind.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Marks Cemetery

Dec 31, 1930

20 UNDERTAKER

ADDRESS

Wm. Peubay Humphrey

Rockville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

per issued.

Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 3 1931

BUREAU V. 8.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH   |                                 |   | 01790      |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |
|--|---------------------------------|---|------------|--|---|--|
| County <u>Montgomery</u>   |                                 |   | (124)      |  | Registration Dist. No. <u>217</u>   |  |
| Village or City <u>Redland</u> (No. _____)   |                                 |   | St.: _____ |  | Ward: _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.) |  |
| 2 FULL NAME <u>Rosa Estella Brigham</u>  |                                 |   |            |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |                                 |   |            |  |   |  |
| 3 SEX<br><u>Female</u>   | 4 COLOR OR RACE<br><u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>married</u><br>(Write the word) |            |  |   |  |
| 6 DATE OF BIRTH<br><u>Dec</u> , 1894<br>(Month) (Day) (Year)   |                                 |   |            |  |   |  |
| 7 AGE<br><u>36</u> yrs. <u>4</u> mos. <u>1</u> ds. or min.?  |                                 |   |            |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession or particular kind of work <u>housewife</u><br>(b) General nature of industry, business, or establishment in which employed or (employer)  |                                 |   |            |  |   |  |
| 9 BIRTHPLACE<br>(State or country) <u>md</u>   |                                 |   |            |  |   |  |
| 10 NAME OF FATHER <u>James Wahlen</u>  |                                 |   |            |  |   |  |
| 11 BIRTHPLACE OF FATHER<br>(State or country) <u>md</u>  |                                 |   |            |  |   |  |
| 12 MAIDEN NAME OF MOTHER <u>Emma Bagen</u>   |                                 |   |            |  |   |  |
| 13 BIRTHPLACE OF MOTHER<br>(State or country) <u>md</u>  |                                 |   |            |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>J. W. Brigham</u><br>(Address) <u>Derwood</u>   |                                 |   |            |  |   |  |
| 15 Filed <u>Feb 27</u> 1930 <u>C. S. Barnes</u> Registrar  |                                 |   |            |  |   |  |
| MEDICAL CERTIFICATE OF DEATH   |                                 |   |            |  |   |  |
| 16 DATE OF DEATH<br><u>Feb</u> , 1930<br>(Month) <u>26</u> (Day) <u>1930</u> (Year)  |                                 |   |            |  |   |  |
| 17 I HEREBY CERTIFY, That I attended the deceased from<br><u>Feb 25</u> 1930 to <u>Feb 26</u> 1930,<br>that I last saw her alive on <u>Feb 26</u> 1930,<br>and that death occurred on the date stated above, at <u>7:15 P</u> m.<br>The CAUSE OF DEATH * was as follows:<br><u>Acute hemorrhagic nephritis</u><br>(Duration) yrs. mos. <u>1</u> ds.<br>Contributory <u>Acute cholecystitis</u><br>Secondary<br>(Duration) yrs. mos. <u>1</u> ds.<br>(Signed) <u>J. L. Brockett</u> M. D.<br><u>2-27</u> 1930 (Address) <u>Gaithersburg Md</u><br>*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. |                                 |   |            |  |   |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)<br>At place of death yrs. mos. ds. In the State yrs. mos. ds.<br>Where was disease contracted, if not at place of death?<br>Former or usual residence   |                                 |   |            |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Gaithersburg</u>   |                                 |   |            |  | DATE OF BURIAL<br><u>Mar 1st</u> 1930   |  |
| 20 UNDERTAKER<br><u>G. B. Galt</u>   |                                 |   |            |  | ADDRESS<br><u>Gaithersburg</u>  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

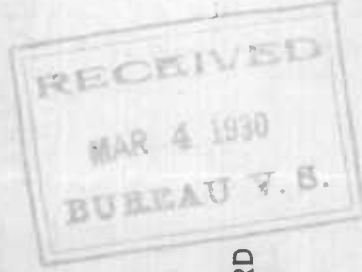
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Form laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Pneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningitis, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Thurgood 12541  
Village or City Cherry Chase (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 214

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Howard Miles Broadbent

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Oct. 10, 1856  
(Month) (Day) (Year)

7 AGE 74 yrs. 70 If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Commodore, U.S.  
(b) General nature of industry, business, or establishment in which employed (or employer) Coast Guard, Ret.

9 BIRTHPLACE (State or country) Phila., Pa.

10 NAME OF FATHER John Broadbent

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER not obtainable

13 BIRTHPLACE OF MOTHER (State or country) \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Broadbent

(Address) W. H. Virginia St.

15 Filed Oct. 30, 1930 W. L. Lewis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1930 to Oct 30, 1930

that I last saw him alive on Oct 30, 1930

and that death occurred on the date stated above, at 3:50 m.

The CAUSE OF DEATH\* was as follows:

Valvular Disease of the Heart

(Duration) 7 yrs. 6 mos. 0 ds.

Contributory Valvular Disease of Heart

(Duration) 7 yrs. 6 mos. 0 ds.

(Signed) W. H. Virginia St. (Address) Phila., Pa.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Washington, D.C.

DATE OF BURIAL 10/30, 1930

20 UNDERTAKER Jos. Cantersone

W. H. Virginia St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 7 1930

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County MontgomeryVillage or City Rockville (No. \_\_\_\_\_)

## 2 FULL NAME

Florence May Brown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

## 6 DATE OF BIRTH

May (w/ew) 1868  
(Month) (Day) (Year)

## 7 AGE

61 yrs. 9 mos. 26 days or min.?

## 8 OCCUPATION

(a) Trade, profession or particular kind of work Cook  
(b) General nature of industry business, or establishment in which employed or (employer) Housework

## 9 BIRTHPLACE (State or country)

Md.

## 10 NAME OF FATHER

George Brown

## 11 BIRTHPLACE OF FATHER (State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

unknown

## 13 BIRTHPLACE OF MOTHER (State or country)

11

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Adams(Address) Rockville15 Filed 2-27 1930 Mrs. W. J. Pratt  
Registrar

01791

(129)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 213

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME, its street and number.)

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Feb. 25 1930  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended the deceased from

Feb. 15 1930 to Feb. 25 1930that I last saw him alive on Feb. 25 1930and that death occurred on the date stated above, at 1:55 P.M.

The CAUSE OF DEATH \* was as follows:

Chronic nephritis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) G. P. Hartley M. D.Feb. 26 1930 (Address) Rockville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

## 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

Good Hope

## DATE OF BURIAL

Feb. 27 1930

## 20 UNDERTAKER

Leo R. Brown

## ADDRESS

RockvilleMd.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scullery, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by falling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 8 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

15127

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 214

Village or City

Silver Spring, Md.915 Philadelphia Ave.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

BROWN, FRANK KARNE

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Married

6 DATE OF BIRTH

Aug 16, 1879  
(Month) (Day) (Year)

7 AGE

51 yrs. 3 mos. 28 ds. or LESS than  
1 day hrs. min?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Plumber

(b) General nature of industry business, or establishment in which employed or (employer)

Quaker Ground9 BIRTHPLACE  
(State or country)Philadelphia, Pa.10 NAME OF  
FATHERFrank P. Brown11 BIRTHPLACE  
OF FATHER  
(State or country)Rhila. Pa.12 MAIDEN NAME  
OF MOTHERKatharine Selkirk13 BIRTHPLACE  
OF MOTHER  
(State or country)Rhila. Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Blanche B. Brown

(Address)

915 Philadelphia Ave. Silver Spring, Md.

15

Filed

Dec 13 1930J. E. Dooling

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec. 13, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Nov. 6, 1928 to Dec. 13, 1930that I last saw him alive on Dec. 12, 1930and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH \* was as follows:

Myocarditis and Chronic  
Mitral regurgitation(Duration) 2 yrs. 3 mos. ds.Contributory  
SecondaryChronic Nephritis(Duration) 2 yrs. mos. ds.

(Signed)

W. P. Mitchell

M. D.

Dec 13 1930 (Address) Silver Spring, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death hrs. mos. ds.In the State hrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Removal Remains to DC. Dec 15 1930

20 UNDERTAKER

ADDRESS

S. H. Harris Co.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1931  
BUREAU V. S.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH   |                                 |  | 05686   |  | STATE OF MARYLAND                 |  |
|--|---------------------------------|--|---|--|-----------------------------------|--|
| County <u>Montgomery</u>   |                                 |  | 742   |  | CERTIFICATE OF DEATH              |  |
| Village or City <u>Leesville</u> (No. _____)   |                                 |  | St. _____   |  | Registration Dist. No. <u>214</u> |  |
| 2 FULL NAME <u>James H. Brown</u>  |                                 |  | (If death occurred in a hospital or institution, give its NAME instead of street and number.) |  |                                   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |                                 |  |   |  |                                   |  |
| 3 SEX<br><u>Male</u>   | 4 COLOR OR RACE<br><u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>Single</u><br>(Write the word) |   |  |                                   |  |
| 6 DATE OF BIRTH<br><u>12 - 23 - 1850</u><br>(Month) (Day) (Year)   |                                 |  |   |  |                                   |  |
| 7 AGE<br><u>79</u> yrs. <u>4</u> mos. <u>15</u> ds. If LESS than 1 day hrs. or min.?   |                                 |  |   |  |                                   |  |
| 8 OCCUPATION<br>(a) Trade, profession or particular kind of work <u>Farmer</u><br>(b) General nature of industry, business, or establishment in which employed or (employer)   |                                 |  |   |  |                                   |  |
| 9 BIRTHPLACE (State or country) <u>Ind.</u>  |                                 |  |   |  |                                   |  |
| 10 NAME OF FATHER <u>John Brown</u>  |                                 |  |   |  |                                   |  |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Ind.</u>   |                                 |  |   |  |                                   |  |
| 12 MAIDEN NAME OF MOTHER <u>Sophia Hargray</u>   |                                 |  |   |  |                                   |  |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Ind.</u>   |                                 |  |   |  |                                   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>J. R. Lissner</u><br>(Address) <u>Leesville Ind.</u>  |                                 |  |   |  |                                   |  |
| 15 Filed <u>May 8 1930</u> <u>J. E. Wadley</u> Registrar   |                                 |  |   |  |                                   |  |
| If more banks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.   |                                 |  |   |  |                                   |  |
| MEDICAL CERTIFICATE OF DEATH   |                                 |  |   |  |                                   |  |
| 16 DATE OF DEATH <u>5 - 8 - 1930</u><br>(Month) (Day) (Year)   |                                 |  |   |  |                                   |  |
| 17 I HEREBY CERTIFY, That I attended the deceased from <u>5/1/1930</u> to <u>5/8/1930</u><br>that I last saw him alive on <u>5/6/1930</u><br>and that death occurred on the date stated above, at <u>3.00 P.</u> m.<br>The CAUSE OF DEATH * was as follows:<br><u>Coronary Arterio Sclerosis</u> |                                 |  |   |  |                                   |  |
| (Duration) <u>4</u> yrs. <u>5</u> mos. <u>5</u> ds.  |                                 |  |   |  |                                   |  |
| Contributory Secondary <u>Coronary Arterio Sclerosis</u>   |                                 |  |   |  |                                   |  |
| (Duration) <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds.  |                                 |  |   |  |                                   |  |
| (Signed) <u>J. R. Lissner</u> M. D.<br><u>5/8/1930</u> (Address) <u>Sandy Spring Md.</u>   |                                 |  |   |  |                                   |  |
| *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.  |                                 |  |   |  |                                   |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)<br>At place of death <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds. In the State <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds.   |                                 |  |   |  |                                   |  |
| Where was disease contracted, if not at place of death?<br>Former or usual residence _____   |                                 |  |   |  |                                   |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>St Marks</u> DATE OF BURIAL <u>5/10, 1930</u>   |                                 |  |   |  |                                   |  |
| 20 UNDERTAKER <u>James C. Humphrey</u> ADDRESS <u>Rockville</u>  |                                 |  |   |  |                                   |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business of industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of a household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucositis; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucositis (disease causing death, 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *seizures, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JUN 7 1930  
BUREAU



MARGIN RESERVED FOR BINDING  
WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Montgomery

08137

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 213

Village or City Brownstown (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Leroy Brown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH 11 21 1929  
(Month) (Day) (Year)

7 AGE 8 yrs. 8 mos. — ds. or — min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work —  
(b) General nature of industry, business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Montg. Co Md

10 NAME OF FATHER Barnett Anderson

11 BIRTHPLACE OF FATHER (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Lethel Anderson

13 BIRTHPLACE OF MOTHER (State or country) Germany Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Martha Brown

(Address) 1338 E. St. N. W.

15 Filed 7/22 1930 Upd. D. Louis Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7-21-1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at 5 30 p.m.

The CAUSE OF DEATH \* was as follows:

Unknown enteric Colitis  
as related to Paratyphoid  
Caul taken

(Duration) 3 yrs. 3 mos. 3 ds.

Contributory  
Secondary

(Duration) 3 yrs. 3 mos. 3 ds.

(Signed) Upd. D. Louis M. D.

7/22 1930 Address Danversville Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. 3 mos. 3 ds. In the State 3 yrs. 3 mos. 3 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Calvary Colored Church 7/22, 1930

20 UNDERTAKER ADDRESS

Ernest Gartin Easternby

No physician in attendance. This child  
Robert Robert in Medical Court and Master  
Born (Philadelphia) Pennsylvania  
13384 St. 11 St.  
Alt. 3. 2 years 4 months & 6 days  
REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Œdema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| 1 PLACE OF DEATH  |                                 |   | 13908                       |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH  |  |
|---|---------------------------------|---|-----------------------------|--|--|--|
| County <u>Montg.</u>  |                                 |   | (74a) <u>Maplewood San.</u> |  | Registration Dist. No. <u>214</u>  |  |
| Village or City <u>Silver Spring</u>  |                                 |   | <u>8720 Maple Ave.</u>      |  | Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.) |  |
| 2 FULL NAME <u>Margaret Brown</u>   |                                 |   |                             |  |  |  |
| PERSONAL AND STATISTICAL PARTICULARS  |                                 |   |                             |  |  |  |
| 3 SEX<br><u>Female</u>  | 4 COLOR OR RACE<br><u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>single</u> |                             |  |  |  |
| 6 DATE OF BIRTH<br>_____, 19____<br>(Month) (Day) (Year)  |                                 |   |                             |  |  |  |
| 7 AGE<br><u>53</u> yrs. ____ mos. ____ ds. If LESS than 1 day ____ hrs. ____ min.?  |                                 |   |                             |  |  |  |
| 8 OCCUPATION<br>(a) Trade, profession or particular kind of work <u>Government Clerk</u><br>(b) General nature of industry business, or establishment in which employed or (employer) _____   |                                 |   |                             |  |  |  |
| 9 BIRTHPLACE (State or country) <u>Virginia</u>   |                                 |   |                             |  |  |  |
| 10 NAME OF FATHER <u>Geo. Brown</u>   |                                 |   |                             |  |  |  |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>  |                                 |   |                             |  |  |  |
| 12 MAIDEN NAME OF MOTHER <u>Margaret Talbot</u>   |                                 |   |                             |  |  |  |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Virginia</u>  |                                 |   |                             |  |  |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Laura Howland</u><br>(Address) <u>Silver Spring</u>  |                                 |   |                             |  |  |  |
| 15 Filed <u>Nov. 11</u> 19 <u>30</u> <u>J. E. Wadley</u> Registrar  |                                 |   |                             |  |  |  |
| MEDICAL CERTIFICATE OF DEATH  |                                 |   |                             |  |  |  |
| 16 DATE OF DEATH <u>Nov 11</u> , 19 <u>30</u><br>(Month) (Day) (Year)   |                                 |   |                             |  |  |  |
| 17 I HEREBY CERTIFY, That I attended the deceased from <u>Nov 7</u> 19 <u>30</u> to <u>Nov 11</u> , 19 <u>30</u><br>that I last saw him alive on <u>Nov 10</u> , 19 <u>30</u> ,<br>and that death occurred on the date stated above, at <u>6 A.</u> m.<br>The CAUSE OF DEATH * was as follows:<br><u>Ruptured cerebral vessel.</u><br>(Duration) ____ yrs. ____ mos. <u>5</u> ds.<br>Contributory <u>arteriosclerosis</u><br>Secondary (Duration) <u>8</u> yrs. <u>0</u> mos. <u>0</u> ds.<br>(Signed) <u>W. B. Haynes</u> M. D.<br>192____ (Address) _____ |                                 |   |                             |  |  |  |
| *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.   |                                 |   |                             |  |  |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)<br>At place of death <u>2</u> yrs. <u>5</u> mos. <u>9</u> ds. In the State ____ yrs. ____ mos. ____ ds.<br>Where was disease contracted, if not at place of death? <u>DC</u><br>Former or usual residence _____  |                                 |   |                             |  |  |  |
| 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL<br><u>Washington D.C.</u> <u>Nov. 11, 1930</u>   |                                 |   |                             |  |  |  |
| 20 UNDERTAKER ADDRESS<br><u>Martin W. Hyslop</u> <u>1300 Nat. Ave.</u><br><u>Wash. D.C.</u>   |                                 |   |                             |  |  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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DEC 8 1930

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Mont -

01792

(57)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City

Olney

(No.)

Mont Co Gen Hosp

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Maud A. Brown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Mar

6 DATE OF BIRTH

May 4<sup>th</sup> 1868

(Month)

(Day)

(Year)

7 AGE

61 yrs. 9 mos. 9 ds.

IF LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

a) Trade, profession or particular kind of work

home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

Md

10 NAME OF  
FATHER

Ulysses Johnson

11 BIRTHPLACE  
OF FATHER  
(State or country)

Md -

12 MAIDEN NAME  
OF MOTHER

Sarah W Brown

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Md -

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Brown

(Address)

Brighton Md

15

Filed Feb 14

1930

C. S. Barnsley

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 13 - 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Feb 5<sup>th</sup> 1930 to Feb 13<sup>th</sup> 1930that I last saw her alive on Feb 13<sup>th</sup> 1930

and that death occurred on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH \* was as follows:

Diabetes Mellitus

Contributory  
SecondaryRuptured appendix with  
abscess - (Duration) 5 yrs. - mos. - ds.

(Signed)

J. W. Birt M. D.  
Feb 14 1930 (Address) Sandy Spring\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death - yrs. - mos. 8 ds. In the State - yrs. - mos. - ds. life

Where was disease contracted, if not at place of death? home

Former or usual residence Brighton Md

19 PLACE OF BURIAL OR REMOVAL

Brighton Md

DATE OF BURIAL

Feb 15 1930

20 UNDERTAKER

Roy Barber

ADDRESS

Fayetteville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 1 1900  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

13909

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 217Village or City Brinklow (No. 129)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME in place of street and number.)

2 FULL NAME Olivia Brown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH June 24 - 1858  
(Month) (Day) (Year)

7 AGE 73 yrs. 5 mos. 6 ds. or \_\_\_\_\_ min.?  
If LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) home

9 BIRTHPLACE (State or country) Ind -

10 NAME OF FATHER Fred. Brown

11 BIRTHPLACE OF FATHER (State or country) Ind -

12 MAIDEN NAME OF MOTHER Annie Warrell

13 BIRTHPLACE OF MOTHER (State or country) Ind -

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred. Jones Jr.(Address) Brinklow

15 Filed Dec 1 1930 C. S. Barnsley  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 30, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 20 1930 to Nov 30, 1930

that I last saw him alive on Nov 29, 1930,

and that death occurred on the date stated above, at 99 m.  
The CAUSE OF DEATH \* was as follows:

Chc. Nephritis

(Duration) 12 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Wrenia  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Chas. Simbleton M. D.

Nov 30 1930 (Address) Sandy Spring

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Woodside Cem Dec 1, 1930

20 UNDERTAKER ADDRESS

Roy Barber Sytonsville Md

per issued.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only, not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer—retired 6 yrs.* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH, the primary affection with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

DEC 3 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sorecoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Bethesda (No. \_\_\_\_\_)

2 FULL NAME Clifford Brown

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 216

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Oct 15, 1930  
(Month) (Day) (Year)

7 AGE 14 yrs. 1 mos. 14 ds. or 14 min. IF LESS than 1 day \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Washington D.C.

10 NAME OF FATHER Robert Lee

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER Dorothy Brown

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dorothy Brown  
(Address) Bethesda Md

15 Filed Nov 29, 1930 Benny C. Perry Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 28, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_ 192\_\_ to \_\_\_\_\_ 192\_\_,

that I last saw him alive on \_\_\_\_\_ 192\_\_,

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH \* was as follows:

Congenital Callosity  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Benny C. Perry M. D.

11 29-30, 1930 (Address) Bethesda Md

\*State the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

10 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bethesda DATE OF BURIAL Nov 29, 1930

20 UNDERTAKER Walter Brown ADDRESS Bethesda

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 6 1930

BUREAU



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montg.

Village or City Leopoldville (No. R725)

2 FULL NAME Mary E. Brunett

03089 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH July 7, 1966  
(Month) (Day) (Year)

7 AGE 64 yrs. 9 mos. 28 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Louis E. Brunett

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary E. Johnson

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Victor Brunett  
(Address) Leopoldville

15 Filed Mar 7 1980 J. E. W. W. W. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 5, 1980  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr 9 1979 to Mar 5 1980, that I last saw him alive on Mar 5 1980

and that death occurred on the date stated above, at 11:00 m. The CAUSE OF DEATH \* was as follows:

Arteriosclerosis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Secondary Exhaustion

(Signed) D. H. M. M. M. M. D.

Mar 6 1980 (Address) 1704-16th Ave

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Glen Md. 3/7, 1980

20 UNDERTAKER ADDRESS

Harner & Humphrey Rockville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Moscoses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1931  
BUR

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Belton (No. \_\_\_\_\_)

2 FULL NAME Bryan

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 217

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Unknown 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Apr 21 - 1930  
(Month) (Day) (Year)

7 AGE Between 2 + 3 mos. in utero If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) MD

10 NAME OF FATHER Edith Bryan

11 BIRTHPLACE OF FATHER (State or country) MD

12 MAIDEN NAME OF MOTHER Bessie M. Thompson

13 BIRTHPLACE OF MOTHER (State or Country) MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. W. S. Cress

(Address) Highland

15 Filed Apr 26 1930 C. S. Barnesley  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. 21 - 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr. 21 - 1930 to \_\_\_\_\_, 192\_\_\_\_.

that I last saw him alive on \_\_\_\_\_, 192\_\_\_\_.

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Mother aborted from unknown cause

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) W. W. S. Cress M. D.

Apr 22 - 1930 (Address) Highland

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Apr 21, 1930

20 UNDERTAKER

ADDRESS

Father

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

*for issue*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the date is essential) and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 6 1920  
U. S. DEPT. OF COMMERCE  
BUREAU OF CENSUS

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Montgomery*

04438

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *216*Village or City *Cherry Chase* (No. *6716 N. Central ave* St. Ward)

(If death occurred in a hospital or institution, give its NAME, its street and number.)

2 FULL NAME

*David Buchanan*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M*

4 COLOR OR RACE

*White*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)☒ MARRIED

6 DATE OF BIRTH

*Unknown*  
(Month) (Day) (Year)

7 AGE

*87* yrs.*Unknown* mos. ds. or min.?IF LESS than  
1 day hrs.  
1 day hrs.  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Carpenter*

(b) General nature of industry, business, or establishment in which employed or (employer)

*(Ret)*

9 BIRTHPLACE

(State or country)

*Canada*

10 NAME OF FATHER

*unk*

11 BIRTHPLACE OF FATHER

(State or country)

*Ireland*

12 MAIDEN NAME OF MOTHER

*unk*

13 BIRTHPLACE OF MOTHER

(State or country)

*Ireland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Fred. J. Leonard*

(Address)

*6716 N. Central ave*

15

Filed *April 21 1930**Ben. C. Perry*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Apr 20 1930*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

*Jan. 28 1930 to Apr. 20, 1930*that I last saw him alive on *Apr. 19, 1930*and that death occurred on the date stated above, at *5 A. m.*

The CAUSE OF DEATH \* was as follows:

*Chronic cardio-vascular degeneration*

(Duration) yrs. mos. ds.

Contributory  
Secondary*Senility*

(Duration) yrs. mos. ds.

(Signed)

*E. G. Bauersfeld* M. D.  
*4/21 1930* (Address) *Bethesda, Md.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Washington D.C.**April 22, 1930*

20 UNDERTAKER

*W. W. Deal*

ADDRESS

*816 - 74 St N.E.  
Washington D.C.*



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Lumber—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia",

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucositis; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucositis* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 5 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.

Registration Dist. No.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than  
1 day hrs.  
yrs. mos. ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER

(State or country)

12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

May 25 1935

C. S. Barnsley

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

1 HEREBY CERTIFY, That I attended the deceased from

192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

~~Heart~~ still from pneumonia  
5 months, cause unknown

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

M. D.

5/25/1935

19230

(Address) Sandy Spring

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

per issued

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Pneumonia*;

RECEIVED

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL pyæmia," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County MontgomeryVillage or City Cherry Chase (No. 18, Hesketh St.; Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 216

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Elizabeth Brawton Holstein Buckingham

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH March 20, 1875  
(Month) (Day) (Year)

7 AGE 55 yrs. 3 mos. 18 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Hay  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER George Wolf Holstein

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Emma Hand Eagle

13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bayer Buckingham(Address) 18 Hesketh St., Cherry Chase, Md.

15 Filed July 9<sup>th</sup> 1930 Thomas K. Conrad  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 8, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to July 8, 1930  
that I last saw her alive on July 8, 1930

and that death occurred on the date stated above, at 6:20 p.m.  
The CAUSE OF DEATH\* was as follows:

Carcinoma of face  
(Duration) yrs. 8 mos. 8 ds.

Contributory Arteriosclerosis  
Secondary Silent to him  
(Duration) yrs. \_\_\_\_ mos. 3 ds.

(Signed) William H. Harrison, M. D.  
July 8, 1930 (Address) 3921 Luganua St.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Lincoln Cem. July 9, 1930

20 UNDERTAKER ADDRESS  
Jos. Sawler's Sons Inc. 1754 R. Ave.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
SEP 3 1900  
BUREAU V. S.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

04439

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 217Village or City Sandy Spring (No. 159-B)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sam Joseph Budd.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M- 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH 2/20/1930  
(Month) (Day) (Year)7 AGE 20 yrs. 1 mos. 29 ds. or min.?  
If LESS than 1 day hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Nurs.  
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) N.Y.10 NAME OF FATHER Frank Hill11 BIRTHPLACE OF FATHER (State or country) N.Y.12 MAIDEN NAME OF MOTHER Susan Hockett13 BIRTHPLACE OF MOTHER (State or country) N.Y.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sam Budd.(Address) Sandy Spring15 Filed Apr 11 1930 C. S. Barnsby  
Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4/9/1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 4/9/1930 to 4/9/1930, that I last saw him alive on \_\_\_\_\_, 192\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

terminal heart disease, I saw  
this boy about 1 year ago, I had  
more doctors & had a previous heart  
condition (Duration) 20 yrs. 1 mos. 1 ds.Contributory acute dilatation of heart  
Secondary myocardial (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(Signed) pro M. D.  
4/10/1930 (Address) Sandy Spring

\*State the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sandy Spring April 11, 1930  
20 UNDERTAKER Geo R. Snowden ADDRESS Rockvilleand.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer—retired 6 yrs.* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., (Carcinoma, Sarcoma, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, *septicaemia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "contributory."* (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

U. S. No. 1

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

05688

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 223  
Washington, Saint Louis & Harp  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH  
County Montgomery  
Village or City Takoma Park  
2 FULL NAME Buhler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female  
4 COLOR OR RACE white  
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) MARRIED  
6 DATE OF BIRTH May 27 1930  
7 AGE 10 yrs. 0 mos. 0 ds. or 0 min. IF LESS than 1 day hrs.  
8 OCCUPATION (a) Trade, profession or particular kind of work None (b) General nature of industry business, or establishment in which employed or (employer)  
9 BIRTHPLACE (State or country) Maryland  
PARENTS  
10 NAME OF FATHER William Herbert Buhler  
11 BIRTHPLACE OF FATHER (State or country) Washington D. C.  
12 MAIDEN NAME OF MOTHER Rebecca Tomlin  
13 BIRTHPLACE OF MOTHER (State or country) Maryland  
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant)  
(Address)  
15 Filed June 2 1930 H. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH  
16 DATE OF DEATH May 28 1930  
17 I HEREBY CERTIFY, That I attended the deceased from May 28 1930 to May 28 1930 that I last saw her alive on May 28 1930 and that death occurred on the date stated above, at 8:30 a.m.  
The CAUSE OF DEATH \* was as follows: Stillborn  
Contributory Secondary Mal development  
(Signed) M. D.  
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)  
At place of death 0 yrs. 0 mos. 0 ds. In the State yrs. mos. ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence  
19 PLACE OF BURIAL OR REMOVAL I request a permit to be ash. DATE OF BURIAL  
20 UNDERTAKER San Antonio of my stillborn child. ADDRESS  
If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1 W. H. Buhler.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The maternal worked on 'laborer,' 'Foreman,' 'Manager,' 'Dealer,' etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, House-keeper, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Partner (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A full data is essential and must be obtained before the certificate is permanently filed.

JUN 4 1930

BUREAU V. S.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Clopper (No. 28)

2 FULL NAME John B Bumbacher

05689

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 215

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Apr 2 1878  
(Month) (Day) (Year)

7 AGE 52 yrs. 1 mos. 7 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed or (employer) Same

9 BIRTHPLACE (State or country) Switzerland

10 NAME OF FATHER Peter S. Bumbacher

11 BIRTHPLACE OF FATHER (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Marie Farber

13 BIRTHPLACE OF MOTHER (State or Country) Switzerland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Bumbacher

(Address) Gaithersburg, Md.

15 Filed May 11 1930 Paul H. Etkin Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 9 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 7 May 1930 to 9 May 1930, that I last saw him alive on 9 May 1930

and that death occurred on the date stated above at 7 P M.  
The CAUSE OF DEATH was as follows:

acute myocarditis  
(Duration) — yrs. — mos. 3 ds.

Contributory  
Secondary

(Duration) — yrs. — mos. — ds.  
(Signed) Stanley W. Farber M. D.  
11 May 1930 (Address) Gaithersburg, Md.

\*State the cause causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 23 yrs. — mos. — ds. In the 23 yrs. — mos. — ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence Same

19 PLACE OF BURIAL OR REMOVAL Clopper, Md. DATE OF BURIAL 12 May 1930

20 UNDERTAKER E. C. Gartner ADDRESS Gaithersburg, Md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY/PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Mont

15128

(129)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City

W Olney

(No.)

Mont Co Gaithersburg

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Henry C. Burch

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

wid-

6 DATE OF BIRTH

Apr 14 1854

(Month)

(Day)

(Year)

7 AGE

76 yrs. 8 mos. 5 ds.

IF LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

laborer

(b) General nature of industry business, or establishment in which employed or (employer)

farm

9 BIRTHPLACE

(State or country)

Va

10 NAME OF FATHER

Frank Burch

11 BIRTHPLACE OF FATHER

Va

12 MAIDEN NAME OF MOTHER

Marriett Newton

13 BIRTHPLACE OF MOTHER

Va

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wasp Records

(Address)

15

Filed

Dec 19

1930

C. B. Barnes

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 19th 1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Nov 21 1930 to Dec 19th 1930

that I last saw him alive on Dec 19th 1930

and that death occurred on the date stated above, at 3:12 m.

The CAUSE OF DEATH \* was as follows:

Chr. Nephritis

(Duration)

unknown

Contributory  
Secondary

Wound

(Duration)

6 ds.

(Signed)

C. S. Smith

M. D.

Dec 19

1930

(Address)

Sandy Spring Md

\*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death - yrs. - mos. 28 ds. In the life State yrs. mos. ds.

Where was disease contracted, if not at place of death? Poolsville Md

Former or usual residence Poolsville Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Beallville Ceme

Dec 21 1930

20 UNDERTAKER

ADDRESS

Hilton &amp; Hall

Poolsville Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

per issued

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Formerly retired 6 yrs.* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Typhoid fever* (avoid use of "Drop"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 3 1901  
BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicemia," "PUERPERAL puerionitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, leaums*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

01793

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 211

Village or City W. Browningville (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Isabel Virginia Burdette

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed  
(Write the word)

6 DATE OF BIRTH March 24 1848  
(Month) (Day) (Year)

7 AGE 81 yrs. 11 mos. 0 ds. or less than 1 day hrs. min.

## 8 OCCUPATION

(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)Ind.

## 10 NAME OF FATHER

Samuel T. Watkins11 BIRTHPLACE OF FATHER  
(State or country)Ind.

## 12 MAIDEN NAME OF MOTHER

Mary Jane Browning13 BIRTHPLACE OF MOTHER  
(State or country)Ind.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Prudence Day

(Address)

P. D. Monrovia Ind.

15 Filed Feb. 24 1930 Della W. Beall  
Regist. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 24 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb. 24 1925 to Feb. 24 1930, that I last saw her alive on Feb. 23 1930

and that death occurred on the date stated above, at 5 a. m.

The CAUSE OF DEATH was as follows:

Chronic EndocarditisContributory  
Secondary

(Duration) 5 or longer yrs. mos. ds.  
Chronic Interstitial Nephritis

(Signed) George M. Boyer M. D.  
Feb. 24 1930 (Address) Damascus, Md.

\*State the Cause Causing Death, or, in death from Violent Cause, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethesda Cemetery  
Browningville, Md. Feb. 26 1930

20 UNDERTAKER

ADDRESS

J. B. Beall, Inc. Damascus, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Corioma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Rockville (No. \_\_\_\_\_)

2 FULL NAME Willis B. Burdett

01794

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 213

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Oct. 26, 1871  
(Month) (Day) (Year)

7 AGE 58 yrs. 3 mos. 25 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Postmaster  
(b) General nature of industry, business, or establishment in which employed or (employer) Rockville, Md.

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Jos. M. Burdett

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Isabel Walker

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. W. T. Burdett

(Address) Rockville Md

15 Filed 2-23 1923 Mrs. W. T. Burdett  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 21, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb. 21, 1930 to Feb. 21, 1930

that I last saw him alive on Feb. 21, 1930

and that death occurred on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH \* was as follows:  
Acute dilatation of heart

Contributory  
Secondary

(Duration) Two minutes  
Chronic myocarditis  
(Signed) W. A. Leathrum M. D.  
Feb. 23, 1930 (Address) Rockville, Md.

\*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Sailersburg Md DATE OF BURIAL 2/23, 1930

20 UNDERTAKER Ed. R. Thompson ADDRESS \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Deputy," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Group"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAR 1908  
PORT

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

12542

# STATE OF MARYLAND CERTIFICATE OF DEATH

 Registration Dist. No. 214

 Village or City Silver Spring (No. Route #1)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

 2 FULL NAME Joseph Ulrich Burkett

## PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

 6 DATE OF BIRTH Dec 28, 1856  
(Month) (Day) (Year)

 7 AGE 73 yrs. 9 mos. 15 ds. If LESS than 1 day hrs. or min.

 8 OCCUPATION  
(a) Trade, profession or particular kind of work Salesman  
(b) General nature of industry business, or establishment in which employed or (employer) National Electric Supply Co.

 9 BIRTHPLACE (State or country) Gettysburg, Pa.

 10 NAME OF FATHER Josiah Burkett

 11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

 12 MAIDEN NAME OF MOTHER Mary Critzman

 13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs James Benedict

 (Address) Silver Spring, Md.

 15 Filed Oct 14 1930 J. E. Dudley Registrar

## MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH October 13, 1930  
(Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from October 12, 1930 to October 13, 1930 that I last saw him alive on October 13, 1930

 and that death occurred on the date stated above, at 12:05 P. m. The CAUSE OF DEATH \* was as follows:

Solar Pneumonia

 (Duration) 2 yrs. 2 mos. 2 ds.

Contributory Secondary

 (Duration) 2 yrs. 2 mos. 2 ds.

 (Signed) H. H. Howlett M. D.

Oct 13, 1930 (Address) 928 Signs are Silver Spring, Md.

\*State the Disease Causing Death, or, if death from Violent Cause, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

 At place of death 2 yrs. 2 mos. 2 ds. In the State 2 yrs. 2 mos. 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Washington D. C.

 20 UNDERTAKER Mrs R. Pearce

 DATE OF BURIAL 10/14, 1930 ADDRESS 316 23 Con way

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state, occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

NOV 7 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic nodular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—typical*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Montgomery

12543

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 216Village or City Kensington (No. 35) Con. Ave St.            Ward            (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Florence May Burner

## PERSONAL AND STATISTICAL PARTICULARS

|                        |                                 |   |
|------------------------|---------------------------------|---|
| 3 SEX<br><u>Female</u> | 4 COLOR OR RACE<br><u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word)<br><u>married</u> |
|------------------------|---------------------------------|---|

6 DATE OF BIRTH June 10th, 1884  
(Month) (Day) (Year)7 AGE 46 yrs. 4 mos. 20 ds. or            min.?  
If LESS than 1 day            hrs.8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer)           9 BIRTHPLACE (State or country) Virginia10 NAME OF FATHER Thomas L. Newcomer11 BIRTHPLACE OF FATHER (State or country) Virginia12 MAIDEN NAME OF MOTHER Mary Allen Coff13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Newcomer(Address) 1462 Clifton St. N.W.D.C.15 Filed 10-30-1930 Thomas K. Conrad Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 29th, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from April 4th, 1929 to Oct 29, 1930, that I last saw him alive on Oct 28th, 1930.and that death occurred on the date stated above, at 12:20 a.m.  
The CAUSE OF DEATH \* was as follows:carcinoma of caecum & ascending colonContributory General asthenia  
Secondary           (Signed) Thomas K. Conrad M. D.  
10-29-1930 (Address) 5904 Con. Ave. Md

\*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients &amp; Recent Residents)

At place of death            yrs.            mos.            ds. In the State            yrs.            mos.            ds.Where was disease contracted, if not at place of death?           Former or usual residence           19 PLACE OF BURIAL OR REMOVAL Rockville Cemetery DATE OF BURIAL Oct 31, 193020 UNDERTAKER W. R. Humphrey ADDRESS Rockville Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 8 1930  
BUREAU

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

01795

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City Takoma Park Md. (No. Wash. San. & Hosp. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Katherine Cook Burnham

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) ✓

6 DATE OF BIRTH December 16, 1847  
(Month) (Day) (Year)

7 AGE 82 yrs. 2 mos. 7 ds. IF LESS than 1 day, hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Norwich, Conn.

10 NAME OF FATHER Peter Lauman

11 BIRTHPLACE OF FATHER (State or country) St. Kitts and Nevis

12 MAIDEN NAME OF MOTHER Katherine Cook

13 BIRTHPLACE OF MOTHER (State or country) Norwich Conn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanitarium Records  
(Address) Takoma Park Md.

15 Filed Feb. 23, 1930 H. E. Rogers  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 23, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb. 23, 1930 to Feb. 23, 1930, that I last saw her alive on Feb. 23, 1930, and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH \* was as follows:

Hypertension

Contributory Secondary Cerebral Hemorrhage

(Signed) M. D. M. D.  
2/23, 1930 (Address) Takoma Park Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death, 1 1/2 mos. In the State, 1 1/2 mos.

Where was disease contracted, if not at place of death?

Former or usual residence 136 S. Leonard St. N.W. Takoma Park Md.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Washington 2/27, 1930

20 UNDERTAKER ADDRESS

H. B. Young 924 N. Y. Ave.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement, never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningeal Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal, peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few details are essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 4 1930  
BUREAU

WRITE PROMPTLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Takoma Park Md. Wash. San. & Hosp.

2 FULL NAME W. George E. Burns.

01796 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 223

Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) MARRIED

6 DATE OF BIRTH March 11 1862  
(Month) (Day) (Year)

7 AGE 67 yrs. 11 mos. 15 ds. If LESS than 1 day... hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work retired  
(b) General nature of industry, business, or establishment in which employed or (employer)...

9 BIRTHPLACE (State or country) Washington DC.

10 NAME OF FATHER Sylvester Burns

11 BIRTHPLACE OF FATHER (State or country) Dublin Ireland

12 MAIDEN NAME OF MOTHER Jane Shakespeare

13 BIRTHPLACE OF MOTHER (State or country) Dublin Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanitarium Records  
(Address) Takoma Park Md.

15 Filed Feb 26 1930 H. C. Rogers Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 26<sup>th</sup> 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 19 1930 to Feb. 26 1930  
that I last saw him alive on Feb 26 1930

and that death occurred on the date stated above, at 12:50 PM

The CAUSE OF DEATH \* was as follows:

Acute Myocarditis  
(Duration) ... yrs. ... mos. ... ds.

Contributory Secondary Arterio Sclerosis  
(Duration) ... yrs. ... mos. ... ds.

(Signed) D. H. Kline M. D.  
Feb 26 1930 (Address) Takoma Park DC

\*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 8 ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1920 Biltmore St. Washington

19 PLACE OF BURIAL OR REMOVAL Washington DC DATE OF BURIAL Feb. 28 1930

20 UNDERTAKER J. J. Offell ADDRESS 133-5-N.W.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Carpenter, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement, never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonæum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 23 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

MAY 4 1908  
BUREAU U. S.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

10524

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City

Rockville

(No.)

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

James Wm Burris

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Mar

6 DATE OF BIRTH

May 31

1861

(Month)

(Day)

(Year)

7 AGE

69 yrs.

3 mos.

3 ds.

If LESS than  
1 day hrs.  
or min.

OCCUPATION

(a) Trade, profession or  
particular kind of work

Farmer

(b) General nature of industry  
business, or establishment in  
which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF  
FATHER

Zedekiah Burris

11 BIRTHPLACE  
OF FATHER

(State or country)

Md

12 MAIDEN NAME  
OF MOTHER

Elizabeth Palmer

13 BIRTHPLACE  
OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Alex Burris

(Address)

Silver Spring Md

15

Filed

Sept 5

1930

C S Barndollar

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 3rd, 1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1926 to

Sept 3rd, 1930

that I last saw him alive on May 30, 1930

and that death occurred on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH \* was as follows:

Chc myocarditis

(Duration) 4 yrs. mos. ds.

Contributory  
Secondary

Acute dilatation

(Duration) yrs. mos. ds.

(Signed)

J W Bird

M. D.

Sept 5, 1930

(Address) Sandy Spring Md

\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place  
of death yrs. mos. ds.In the  
State yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Joy Hill Cem

Sept 6, 1930

20 UNDERTAKER

ADDRESS

Warner Pumphrey

Rockville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 4 1930

BUREAU 78

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Maryland

Village or City Poolesville

2 FULL NAME Idella Bussey

12544

(129)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 212

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow  
(Write the word)

6 DATE OF BIRTH Apr 30 1860  
(Month) (Day) (Year)

7 AGE 70 yrs. 5 mos. 22 ds. IF LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Harrison Lee  
11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Elba Lee

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha Bussey  
(Address) Poolesville

15 Filed Oct 25 1930 E. W. White  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 22 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 1930 to Oct 22 1930  
that I last saw him alive on Oct 21 1930  
and that death occurred on the date stated above, at 10:30 P.M.  
The CAUSE OF DEATH \* was as follows:

chronic interstitial nephritis & mitral insufficiency  
(Duration) 2 yrs. mos. ds.

Contributory Woman  
Secondary Person (Duration) 3 yrs. mos. ds.

(Signed) E. W. White M. D.  
Oct 25 1930 (Address) Poolesville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. mos. ds. In the State \_\_\_\_\_ yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Morristown DATE OF BURIAL Oct 25 1930

20 UNDERTAKER Hillout & Hall ADDRESS Poolesville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., etc.* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data if essential and must be obtained before the certificate is permanently filed.

NOV 8 1930

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PLACE OF DEATH

County MontgomeryVillage or City Emory Grove (No. \_\_\_\_\_)2 FULL NAME Cassie Belle Butler

0563

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 218
 St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

 3 SEX female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, single WIDOWED, OR DIVORCED (Write the word)

 6 DATE OF BIRTH July 7, 1923  
 (Month) (Day) (Year)

 7 AGE 6 yrs. 6 mos. 4 ds. or 1 day 4 hrs. If LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.

 8 OCCUPATION  
 (a) Trade, profession or particular kind of work none  
 (b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

 9 BIRTHPLACE (State or country) Ind

 10 NAME OF FATHER Paul Butler

 11 BIRTHPLACE OF FATHER (State or country) Ind

 12 MAIDEN NAME OF MOTHER Effie Dorsey

 13 BIRTHPLACE OF MOTHER (State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) Effie Dorsey Nelson  
 (Address) Gaithersburg B & D

 15 Filed Jan 11, 1930 V. H. Dyeon Registrar

## MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH Jan 11, 1930  
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from Jan 10, 1930 to Jan 11, 1930, that I last saw her alive on Jan 9, 1930, and that death occurred on the date stated above, at 1:30 A. M.

The CAUSE OF DEATH \* was as follows:

Broncho-Pneumonia(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 12 ds.Contributory Secondary unknown of any

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) V. H. Dyeon M. D.Jan 11, 1930. (Address) Gaithersburg Ind

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Emory Grove Country Jan 13, 1930

20 UNDERTAKER ADDRESS

E. C. Garton Gaithersburg



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 6 1930  
BUREAU V. S.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Wt.

Village or City Liber Spring (No. Maplewood Ln. St.)

2 FULL NAME Emma Reese Butler

6564 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 214

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Oct. 7, 1877  
(Month) (Day) (Year)

7 AGE 59 yrs. 0 mos. 28 ds. or LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Leven Thomas

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Nannie Lrendell

13 BIRTHPLACE OF MOTHER (State or Country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard T. Butler

(Address) Polomae Ind.

15 Filed Jan 10, 1930 J. E. Dudley Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 9, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 8, 1930 to Jan 9, 1930  
that I last saw him alive on Jan 8, 1930

and that death occurred on the date stated above, at 1:30 A. m.  
The CAUSE OF DEATH \* was as follows:

Acute Dilatation of heart

(Duration) 2 yrs. 0 mos. 0 ds.

Contributory Arteriosclerosis  
Secondary

(Duration) 2 yrs. 0 mos. 0 ds.

(Signed) W. K. Hays M. D.

Jan 9, 1930 (Address) Liber Spring Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 12 ds. In the State 2 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? Ind.

Former or usual residence Ind.

19 PLACE OF BURIAL OR REMOVAL

Beallsville Ind.

DATE OF BURIAL

1/11/1930

20 UNDERTAKER

Warner & Humphrey

ADDRESS

Beallsville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysentery* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 7 1930  
BUREAU OF VITALS

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|  |                                 |  |   |  |
|--|---------------------------------|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Montgomery</u>   |                                 |  | 10525 STATE OF MARYLAND<br>CERTIFICATE OF DEATH |  |
| Village or City <u>Takoma Park</u> (No. <u>708</u> Erie Ave. St. <u>708</u> Ward <u>223</u> )  |                                 |  | Registration Dist. No. <u>223</u>               |  |
| 2 FULL NAME <u>Rosa Nell Carlton</u>   |                                 |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |                                 |  |   |  |
| 3 SEX<br><u>Female</u>   | 4 COLOR OR RACE<br><u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>child</u><br>(Write the word) |   |  |
| 6 DATE OF BIRTH<br><u>April 12</u> , 19 <u>25</u><br>(Month) (Day) (Year)  |                                 |  |   |  |
| 7 AGE<br><u>5</u> yrs. <u>5</u> mos. <u>1</u> ds. If LESS than 1 day, hrs. or min.?  |                                 |  |   |  |
| OCCUPATION<br>(a) Trade, profession or particular kind of work <u>child</u><br>(b) General nature of industry, business, or establishment in which employed or (employer)  |                                 |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Va.</u>   |                                 |  |   |  |
| 10 NAME OF FATHER <u>Joseph C. Carlton</u>   |                                 |  |   |  |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Va.</u>  |                                 |  |   |  |
| 12 MAIDEN NAME OF MOTHER <u>Nell Beazley</u>   |                                 |  |   |  |
| 13 BIRTHPLACE OF MOTHER (State or Country) <u>Va.</u>  |                                 |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Joseph C. Carlton</u><br>(Address) <u>708 Erie Ave</u>  |                                 |  |   |  |
| 15 Filed <u>Sept 11</u> , 19 <u>30</u> <u>H. E. Rogers</u><br>Registrar  |                                 |  |   |  |
| MEDICAL CERTIFICATE OF DEATH   |                                 |  |   |  |
| 16 DATE OF DEATH<br><u>September 11</u> , 19 <u>30</u> (Month) <u>11</u> (Day) <u>1930</u> (Year)  |                                 |  |   |  |
| 17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept. 1</u> , 19 <u>30</u> to <u>Sept 12</u> , 19 <u>30</u> .<br>that I last saw him alive on <u>Sept 10</u> , 19 <u>30</u> .<br>and that death occurred on the date stated above, at <u>6:30 a. m.</u><br>The CAUSE OF DEATH * was as follows:<br><u>Encephalitis or sleeping sickness.</u><br>(Duration) <u>12</u> yrs. <u>12</u> mos. <u>12</u> ds. |                                 |  |   |  |
| Contributory Secondary<br>(Duration) <u>12</u> yrs. <u>12</u> mos. <u>12</u> ds.   |                                 |  |   |  |
| (Signed) <u>A. B. Little</u> M. D.<br><u>Sept 11</u> , 19 <u>30</u> (Address) <u>6911 5th NW, Wash. DC</u>   |                                 |  |   |  |
| *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.  |                                 |  |   |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)<br>At place of death <u>12</u> yrs. <u>12</u> mos. <u>12</u> ds. In the State <u>12</u> yrs. <u>12</u> mos. <u>12</u> ds.<br>Where was disease contracted, if not at place of death?<br>Former or usual residence   |                                 |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Spanta, Va.</u> DATE OF BURIAL <u>Sept 12</u> , 19 <u>30</u>  |                                 |  |   |  |
| 20 UNDERTAKER <u>W. E. Rogers</u> ADDRESS <u>1421 Blagden</u><br><u>Wash. D. C.</u>  |                                 |  |   |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farm (last year) 6 yrs.* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia"),

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

OCT 6 1930  
BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Rockville (No. (Autopsy))

2 FULL NAME Henson B. Carroll

STATE OF MARYLAND  
CERTIFICATE OF DEATH

01737

197

Registration Dist. No. 213

St: \_\_\_\_\_ Ward: \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH October 15, 1903  
(Month) (Day) (Year)

7 AGE 26 yrs. 3 mos. 16 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Day laborer  
(b) General nature of industry business, or establishment in which employed or (employer) None

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Henson Carroll

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Florence Hayes

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Forest Carroll  
(Address) Rockville, Md

15 Filed 2-3 1930 Mrs. H. T. Pratt  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 1, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192\_\_ to \_\_, 192\_\_,

that I last saw him alive on \_\_, 192\_\_,

and that death occurred on the date stated above, at \_\_ m.

The CAUSE OF DEATH was as follows: Sleep

Hemorrhage and shock

(Duration) \_\_ yrs. \_\_ mos. \_\_ ds.

Contributory Secondary Gunshot wound  
Homicide

(Duration) \_\_ yrs. \_\_ mos. \_\_ ds.

(Signed) M. J. Davis M. D.  
Feb 2 192\_\_ (Address) Rockville, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_ yrs. \_\_ mos. \_\_ ds. In the State \_\_ yrs. \_\_ mos. \_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hanti, Md DATE OF BURIAL 2-4, 1930

20 UNDERTAKER Harner E. Humphrey ADDRESS Rockville, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

12545

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City Olney (No. Mont Co Gen Hosp) St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME James M. Carter

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Sept 24th 1929  
(Month) (Day) (Year)

7 AGE 1 yrs. 0 mos. 11 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) none

9 BIRTHPLACE (State or country) Md -

10 NAME OF FATHER Ezra Carter

11 BIRTHPLACE OF FATHER (State or country) Md -

12 MAIDEN NAME OF MOTHER Myrtle Carter

13 BIRTHPLACE OF MOTHER (State or country) Md -

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ezra Carter

(Address) Germantown Md #2 Rd

15 Filed Oct 6 1930 C. S. Burnley  
Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 5th 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 27 1930 to Oct 5th 1930  
that I last saw him alive on Sept Oct 4th 1930

and that death occurred on the date stated above, at 9 9 a.m.  
The CAUSE OF DEATH \* was as follows:

Acute Dysentery (Gastroenteritis)  
(Duration) — yrs. — mos. 20 ds.

Contributory  
Secondary

(Signed) Charles Umbleton M. D.  
Oct 5th 1930 (Address) Sandy Spring Md

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. 8 ds. In the life State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? Germantown Md

Former or usual residence Germantown Md

19 PLACE OF BURIAL OR REMOVAL Darnestown Md DATE OF BURIAL Oct 7 1930

20 UNDERTAKER Wm Garby Humphrey ADDRESS Rockville Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

NOV 4 1930

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

V. S. No. 1

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

06816 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 211

Village or City Tamassens Md

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Myrtle Louise Carter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH June - 1, 1893  
(Month) (Day) (Year)

7 AGE 37 yrs. 0 mos. 0 ds. or min.?  
(If LESS than 1 day hrs.)

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Percy Gray

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Lula Taylor

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Carter  
(Address) Tamassens Md

15 Filed June 3 1930 Della H. Beall  
Deft. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6-1-1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 4/25 1930 to 5/18 1930, that I last saw her alive on 5/18 1930 and that death occurred on the date stated above, at 11 P. m. The CAUSE OF DEATH \* was as follows:

Uremia  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory mitral stenosis  
Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. A. Smith M. D.  
6/2 1930 (Address) Yadsworth Md  
\*State the 1 is cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Friendship Md DATE OF BURIAL 6/3 1930

20 UNDERTAKER G. B. Beall, Inc. ADDRESS Beall, Inc. Tamassens Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever*, (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mesles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile" etc., "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

06817

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 213

Village or City Potomac, Md.

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Margaret Case

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH February 7, 1896  
(Month) (Day) (Year)

7 AGE 44 yrs. 4 mos. 22 ds. or LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

8 OCCUPATION (a) Trade, profession or particular kind of work At home (b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER George Peters

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy Beall

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles S. Case  
(Address) Potomac, Md.

15 Filed 1/2 1923 Mrs. H. J. Pratt  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 29, 1930  
(Month) (Day) (Year)

1 HEREBY CERTIFY, That I attended the deceased from May 10, 1930 to June 29, 1930, that I last saw her alive on June 29, 1930, and that death occurred on the date stated above, at 8:28 m. The CAUSE OF DEATH was as follows: Intestinal Hemorrhage -

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory Carcinoma of Gall Bladder  
Secondary approximately (Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) John M. Baber M. D.  
July 1, 1930 (Address) 1819 - G St. NW, Washington, D.C.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence In Maryland all her life.

19 PLACE OF BURIAL OR REMOVAL St Marys Rockville DATE OF BURIAL July 2, 1930

20 UNDERTAKER Harner Humphrey ADDRESS Rockville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (c) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JUL 7 1930  
BUREAU

N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Silver Spring (No. \_\_\_\_\_)

2 FULL NAME George Theodore Cashell

09373

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH

August 5, 1857  
(Month) (Day) (Year)

7 AGE

73 yrs. — mos. 5 ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work Watchman  
(b) General nature of industry, business, or establishment in which employed or (employer) U.S. Treasury

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Thomas Franklin Cashell

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Esther Jefferson

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. G. T. Cashell

(Address)

Silver Spring, Md.

15

Filed Aug 11 1930

J. E. Hudling  
Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 10, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 20, 1930 to August 10, 1930  
that I last saw him alive on August 9, 1930

and that death occurred on the date stated above, at 4:40 P.M.  
The CAUSE OF DEATH \* was as follows:

Chronic Myocarditis with Arteriosclerosis  
(Duration) 4 yrs. — mos. — ds.

Contributory Secondary

Cerebral hemorrhage  
(Duration) — yrs. — mos. — ds.

(Signed) H. H. Hoveltt M. D.  
Aug. 10, 1930 (Address) 928 Beigo Ave Silver Spring Md

State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rockville Md.

8, 12, 1930

20 UNDERTAKER

ADDRESS

Harner Humphrey Rockville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Montgomery County General Hosp., Olney, Md.

2 FULL NAME Mellie Smith Castle

15129 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 217

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH August 26, 1910  
(Month) (Day) (Year)

7 AGE 20 yrs. 3 mos. 27 ds. or IF LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Jefferson, Md.

10 NAME OF FATHER Clifford S. Smith

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Viola M. Allen

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eugene Castle  
(Address) Rockville, Md.

15 Filed Dec 23, 1930 C. S. Barnsley  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 23, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec. 20, 1930 to Dec. 23, 1930

that I last saw him alive on Dec. 23, 1930

and that death occurred on the date stated above, at 3:40 P. m.

The CAUSE OF DEATH \* was as follows:

Acute generalized peritonitis  
(Colon Perforation)

(Duration) 3 yrs. 3 mos. 3 ds.

Contributory Ruptured appendix  
Secondary

(Duration) 3 ds.

(Signed) Wm A. Fentress M. D.

Dec. 23, 1930 (Address) Rockville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 2 mos. 2 ds. In the State 2 yrs. 2 mos. 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Jefferson, Md. DATE OF BURIAL Dec 26, 1930

20 UNDERTAKER M. R. Etchison & Son, Frederick, Md. ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former retired 6 yrs.* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the **IMMEDIATE CAUSE OF DEATH** the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 3 1931

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD  
 N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Montgomery

15130

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 213Village or City Rockville (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME (Stillborn) Castle

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Unknown 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Stillborn  
(Write the word)6 DATE OF BIRTH Dec. 16, 1930  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. or \_\_\_\_\_ min.

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Md.10 NAME OF FATHER Eugene Martin Castle11 BIRTHPLACE OF FATHER (State or country) Md.12 MAIDEN NAME OF MOTHER Nellie Georgia Smith13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nellie G. Castle  
(Address) Rockville15 Filed 12-16 1930 20 mos. 26 7 Cast  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 16, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from \_\_\_\_\_, 192\_\_\_\_, to \_\_\_\_\_, 192\_\_\_\_, that I last saw him alive on \_\_\_\_\_, 192\_\_\_\_, and that death occurred on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH was as follows:  
(Stillborn)Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) G. T. Hartley M. D.  
Dec. 17, 1930 (Address) Rockville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Rockville DATE OF BURIAL Dec. 16, 193020 UNDERTAKER Eugene M. Castle ADDRESS Rockville

(over)

*For authorization to add color see birth certificate. ad. 2/9/31.*

## REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (nervous symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 6 1931

BUREAU V. S.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B. Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Montgomery*

Village or City

*Perry Chase*

(No.)

*5 Hayes Ln.*

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*Charles Caravanagh*STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *216*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*male*

4 COLOR OR RACE

*C*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*married*

6 DATE OF BIRTH

*Unknown*

(Month)

(Day)

(Year)

7 AGE

*Unknown*If LESS than  
1 day \_\_\_\_ hrs.  
\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. or \_\_\_\_ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

*Laborer*

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

*Virginia*

10 NAME OF FATHER

*John Tyler Caravanagh*

11 BIRTHPLACE OF FATHER

(State or country)

*Va.*

12 MAIDEN NAME OF MOTHER

*Mary Charles*

13 BIRTHPLACE OF MOTHER

(State or country)

*Va.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mary Gilleain*

(Address)

*Perry Chase, Md.*

15 Filed

*Sept. 23 1923**Benj. D. Perry*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Sept. 21, 1923*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*Sept. 20, 1923*

to

*Sept. 21, 1923*

that I last saw him alive on

*Sept. 21, 1923*

and that death occurred on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

*Cerebral hemorrhage*

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

*E. L. Laversford*

M. D.

(Address)

*Bethesda, Md.*

\*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

13 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

*Evergreen Cemetery, Va.*

DATE OF BURIAL

*Sept. 24, 1923*

20 UNDERTAKER

*Geo R. Snowden*

ADDRESS

*Rockville,*

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation MEANS OF INJURY taken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING  
WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montg.

Village or City Clarkesburg No. 82 St.        Ward        (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Huey Chaney

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE Col. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married (Write the word)

6 DATE OF BIRTH Sept 30 1861 (Month) (Day) (Year)

7 AGE 69 yrs. 5 mos. 25 ds. or min. If LESS than 1 day hrs. or min.?

8 OCCUPATION (a) Trade, profession or particular kind of work Laborer (b) General nature of industry business, or establishment in which employed or (employer) Same

9 BIRTHPLACE (State or country) MD.

PARENTS

10 NAME OF FATHER Isaac Chaney

11 BIRTHPLACE OF FATHER (State or country) MD.

12 MAIDEN NAME OF MOTHER Harriet Thomas

13 BIRTHPLACE OF MOTHER (State or Country) MD.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) asa Chaney (Address) Clarkesburg Md

15 Filed Oct 3 1923 W. G. L. L. L. Registrar

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 30 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 3 mar 1923 to 13 march 1923 that I last saw him alive on 10 july 1923 and that death occurred on the date stated above, at 7:30 p. m. The CAUSE OF DEATH \* was as follows: did suddenly. Probably acute myocarditis. (Duration) ? yrs. mos. ds.

Contributory Secondary (Duration)        yrs. mos. ds.

(Signed) Stanley W. Basher 1 Oct 30 1923 (Address) Guthrie

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death 69 yrs. 5 mos. 25 ds. In the State Same Where was disease contracted, if not at place of death? Same Former or usual residence Same

19 PLACE OF BURIAL OR REMOVAL Rocky Hill Md DATE OF BURIAL 3 Oct 30 1923

20 UNDERTAKER E. C. Gartner ADDRESS Guthrie Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—apophthalmic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All that is essential and must be obtained before the certificate is permanently filed

NOV 5 1930  
BUREAU V.S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1 PLACE OF DEATH<br>County <u>Montgomery</u>  |  | 05690  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH  |  |
| Village or City <u>Gaithersburg</u> (No. _____)   |  | 90   |  | Registration Dist. No. <u>218</u>  |  |
| 2 FULL NAME <u>Eliza Elsworth Chase</u>   |  | St. _____  |  | Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.) |  |
| PERSONAL AND STATISTICAL PARTICULARS  |  |  |  |  |  |
| 3 SEX<br><u>Female</u>  | 4 COLOR OR RACE<br><u>Black</u>                            | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Married</u> |  |  |  |
| 6 DATE OF BIRTH <u>September 6, 1855</u><br>(Month) (Day) (Year)  |  |  |  |  |  |
| 7 AGE <u>64</u> yrs. <u>8</u> mos. <u>5</u> ds. or min.?  |  |  |  |  |  |
| 8 OCCUPATION<br>(a) Trade, profession or particular kind of work <u>Domestic</u><br>(b) General nature of industry, business, or establishment in which employed or (employer)  |  |  |  |  |  |
| 9 BIRTHPLACE (State or country) <u>Maryland</u>   |  |  |  |  |  |
| PARENTS   | 10 NAME OF FATHER <u>Wilton Washington</u>                 |  |  |  |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> |  |  |  |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Unknown</u>                    |  |  |  |  |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>  |  |  |  |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  |  |  |  |  |  |
| (Informant) <u>Geo H Chase</u>  |  |  |  |  |  |
| (Address) <u>Gaithersburg</u>   |  |  |  |  |  |
| 15 Filed <u>May 23 1930</u> <u>Backel Dore Station</u> Registrar  |  |  |  |  |  |
| MEDICAL CERTIFICATE OF DEATH  |  |  |  |  |  |
| 16 DATE OF DEATH <u>May 21, 1930</u><br>(Month) (Day) (Year)  |  |  |  |  |  |
| 17 I HEREBY CERTIFY, That I attended the deceased from <u>May 20, 1930</u> to <u>May 21, 1930</u> , that I last saw her alive on <u>May 20, 1930</u> , and that death occurred on the date stated above, at <u>8:45 A.M.</u> The CAUSE OF DEATH * was as follows: |  |  |  |  |  |
| <u>Acute Cardiac Deletator</u>  |  |  |  |  |  |
| (Duration) _____ yrs. _____ mos. <u>1/2</u> ds.   |  |  |  |  |  |
| Contributory <u>Chronic Valvular heart disease</u>  |  |  |  |  |  |
| Secondary (Duration) _____ yrs. _____ mos. _____ ds.  |  |  |  |  |  |
| (Signed) <u>J J Burchard</u> M. D.  |  |  |  |  |  |
| <u>5-21-</u> 1930 (Address) <u>Gaithersburg Md</u>  |  |  |  |  |  |
| *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.   |  |  |  |  |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)  |  |  |  |  |  |
| At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.  |  |  |  |  |  |
| Where was disease contracted, if not at place of death?   |  |  |  |  |  |
| Former or usual residence _____   |  |  |  |  |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Brook Grove</u>  |  |  |  | DATE OF BURIAL <u>May 23, 1930</u>   |  |
| 20 UNDERTAKER <u>Roy W Barber</u>   |  |  |  | ADDRESS <u>Gaithersburg</u>  |  |
| If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.   |  |  |  |  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Silesian, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Form laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrub, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Bethesda

(No.)

2 FULL NAME

Infant Childress

106 Auburn Ave.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Dec. 16, 1930

(Month)

(Day)

(Year)

7 AGE

— yrs. — mos. — ds. or 5 min.?

If LESS than 1 day — hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

infant

(b) General nature of industry, business, or establishment in which employed or (employer)

premature

9 BIRTHPLACE

(State or country)

Montgomery Co., Md.

10 NAME OF FATHER

Lennie W. Childress

11 BIRTHPLACE OF FATHER

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Wilmington

13 BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lennie W. Childress

(Address) 106 Auburn Ave.

15

Filed

192

no permit issued

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec. 16th 1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Dec. 16, 1930 to Dec. 16th, 1930

that I last saw him alive on Dec. 16th, 1930

and that death occurred on the date stated above, at 3:25 a.m.

The CAUSE OF DEATH \* was as follows:

Premature Birth (4 1/2 months)

(lived about 5 minutes)

Contributory Secondary

Signed) M. D.

Dec. 16, 1930 (Address) Bethesda, Md.

\*State the Cause Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

premature 4 1/2 mos.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

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BUREAU OF

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| PLACE OF DEATH  |   |   | STATE OF MARYLAND<br>CERTIFICATE OF DEATH  |  |
|---|---|---|--|--|
| County <u>Maryland</u>  |   |   | 09374  |  |
| Village or City <u>Cherry Chase</u>   |   |   | Registration Dist. No. <u>216</u>  |  |
| 2 FULL NAME <u>Mary Louisa Childs</u>   |   |   | (If death occurred in a hospital or institution, give its NAME instead of street and number.)  |  |
| PERSONAL AND STATISTICAL PARTICULARS  |   |   |  |  |
| 3 SEX<br><u>F</u>   | 4 COLOR OR RACE<br><u>W</u>                             | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Single</u> | 16 DATE OF DEATH <u>Aug 13</u> , 19 <u>30</u><br>(Month) (Day) (Year)  |  |
| 6 DATE OF BIRTH <u>Jan 6</u> , 18 <u>56</u><br>(Month) (Day) (Year)   |   |   | 17 I HEREBY CERTIFY, That I attended the deceased from <u>July 9</u> , 19 <u>30</u> , to <u>Aug 13</u> , 19 <u>30</u> , that I last saw her alive on <u>Aug 11</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>2:30 A.</u> m. |  |
| 7 AGE <u>74</u> yrs. <u>8</u> mos. <u>7</u> ds. or <u>1</u> day <u>0</u> hrs. <u>0</u> min. IF LESS than  |   |   | The CAUSE OF DEATH * was as follows:<br><u>Carcinoma of Stomach</u>  |  |
| 8 OCCUPATION<br>(a) Trade, profession or particular kind of work <u>None</u><br>(b) General nature of industry business, or establishment in which employed or (employer) |   |   | Contributory <u>Exhaustion</u><br>Secondary  |  |
| 9 BIRTHPLACE (State or country) <u>Conn.</u>  |   |   | (Duration) <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds.  |  |
| PARENTS   | 10 NAME OF FATHER <u>Rev. Thos. D. Childs D.D.</u>      |   | (Duration) <u>10</u> yrs. <u>0</u> mos. <u>0</u> ds.   |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Mass.</u> |   | (Signed) <u>W. L. Secors</u> M. D.<br><u>Aug 13</u> , 19 <u>30</u> (Address) <u>Remington</u>  |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Mary Porter</u>             |   | *State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.  |  |
| 13 BIRTHPLACE OF MOTHER (State or Country) <u>Conn.</u>   |   |   | 10 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  |   |   | At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.   |  |
| (Informant) <u>Miss Fanny Childs</u>  |   |   | Where was disease contracted, if not at place of death?  |  |
| (Address) <u>Cherry Chase</u>   |   |   | Former or usual residence  |  |
| 15 Filed <u>Aug 14</u> , 19 <u>30</u> <u>Thos. D. Childs</u> Registrar  |   |   | 19 PLACE OF BURIAL OR REMOVAL <u>Rock Creek DC</u>   |  |
|   |   |   | DATE OF BURIAL <u>Aug</u> , 19 <u>30</u>   |  |
|   |   |   | 20 UNDERTAKER <u>Jos. Sawber's Sons</u>  |  |
|   |   |   | ADDRESS <u>1754 B. Ave.</u>  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
SEP 3 1930  
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N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Montgomery</u>  |  | 06818   |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |
| Village or City <u>Germanstown</u> (No. ....)   |  | St. ....  |  | Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.) |  |
| 2 FULL NAME <u>William Griffith Cissel</u>  |  | Registration Dist. No. <u>212</u>   |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS  |  |   |  |   |  |
| 3 SEX<br><u>Male</u>  | 4 COLOR OR RACE<br><u>White</u>                            | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br><u>Married</u><br>(Write the word) |  |   |  |
| 6 DATE OF BIRTH<br><u>January 12, 1895</u><br>(Month) (Day) (Year)  |  |   |  |   |  |
| 7 AGE<br><u>35</u> yrs. <u>5</u> mos. <u>8</u> ds. or If LESS than 1 day ____ hrs. ____ min.)   |  |   |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession or particular kind of work <u>Farmer</u><br>(b) General nature of industry business, or establishment in which employed or (employer) _____   |  |   |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Maryland</u>   |  |   |  |   |  |
| PARENTS   | 10 NAME OF FATHER <u>Richard Humphrey Cissel</u>           |   |  |   |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> |   |  |   |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Julia Griffith</u>             |   |  |   |  |
|   | 13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u> |   |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Oliver S. Walters</u><br>(Address) <u>Germanstown</u>  |  |   |  |   |  |
| 15 Filed <u>6/21</u> 19 <u>30</u> <u>W. P. Humphrey Jr.</u> Registrar   |  |   |  |   |  |
| MEDICAL CERTIFICATE OF DEATH  |  |   |  |   |  |
| 16 DATE OF DEATH <u>June 20, 1930</u><br>(Month) (Day) (Year)   |  |   |  |   |  |
| 17 I HEREBY CERTIFY, That I attended the deceased from <u>June 13, 1930</u> to <u>June 20, 1930</u><br>that I last saw him alive on <u>June 20, 1930</u><br>and that death occurred on the date stated above, at <u>6-30</u> m.<br>The CAUSE OF DEATH * was as follows:<br><u>Acute Lobar Pneumonia</u> |  |   |  |   |  |
| Contributory (Duration) yrs. mos. ds. <u>Head Cold</u><br>Secondary (Duration) yrs. mos. ds. <u>10</u>  |  |   |  |   |  |
| (Signed) <u>W. P. Humphrey Jr.</u> M. D.<br><u>6/20</u> 19 <u>30</u> (Address) <u>Rockville</u>   |  |   |  |   |  |
| *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.   |  |   |  |   |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)<br>At place of death yrs. mos. ds. In the State yrs. mos. ds.<br>Where was disease contracted, if not at place of death?<br>Former or usual residence  |  |   |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Monacacy Cem. Beallville</u>  |  |   |  | DATE OF BURIAL<br><u>June 22, 1930</u>  |  |
| 20 UNDERTAKER<br><u>W. P. Humphrey Jr.</u>  |  |   |  | ADDRESS<br><u>Rockville</u>   |  |

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.





N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Keensington (No. \_\_\_\_\_)

2 FULL NAME Charles Clagett

08138

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Apr. 7<sup>th</sup>, 1930  
(Month) (Day) (Year)

7 AGE 3 yrs. 18 mos. 18 ds. IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Ellis Clagett

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Glady's Fife

13 BIRTHPLACE OF MOTHER (State or country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Clagett  
(Address) Keensington, Md.

15 Filed July 26 1930 W. L. Davis Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 25, 1930.  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Lead when first seen to 1930, that I last saw him alive on, 1930.

and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH \* was as follows:

Asphyxiation  
Infant was found accidental.  
in bed with rubber blanket about its head.  
Contributory Duration: 7 hrs. of an hour.  
Secondary Duration: 7 hrs. 15 mos. 1 ds.

(Signed) E. G. Davis M. D.  
July 26, 1930 (Address) Bethesda, Md.

\*state the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Rockville, Md. DATE OF BURIAL July 26, 1930

20 UNDERTAKER W. R. Humphrey ADDRESS Rockville Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Emhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Laytonville (No. \_\_\_\_\_)

2 FULL NAME John T. Claggett

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Dec 16, 1876  
(Month) (Day) (Year)

7 AGE 54 yrs. 0 mos. 2 ds. or min.? If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Farm work  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Charles A. Claggett

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Antonia Snowden

13 BIRTHPLACE OF MOTHER (State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Newman  
(Address) Centersburg

15 Filed Dec 19 1930 J. H. Dyson  
Registrar

## STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 218

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 18, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from was found dead in bed on above date about 8 P.M.  
that I last saw him alive on \_\_\_\_\_, 192\_\_\_\_.

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Mitral Cardiac Disease

Contributory  
Secondary

(Duration) unknown yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Mitral Cardiac Insufficiency  
(Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. H. Dyson M. D.  
Dec 19 1930 (Address) Laytonville Ind

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brook Grove 12/20, 1930

20 UNDERTAKER

ADDRESS

Roy W. Barber Centersburg

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
JAN 6 1931  
BUREAU



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Barnesville (No. 1)

2 FULL NAME Still Birth

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 212

St. blaggett Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH 2-26-1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min. 2 If LESS than 1 day 0 hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Barnesville, Ind.

10 NAME OF FATHER Ernest Claggett

11 BIRTHPLACE OF FATHER (State or country) Barnesville, Ind.

12 MAIDEN NAME OF MOTHER Mary Whalen

13 BIRTHPLACE OF MOTHER (State or country) Ind. Co., Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Claggett

(Address) Barnesville, Ind.

15 Filed Feb 26 1930 Mrs. C. C. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2-26-1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from 2-26-1930 to 2-26-1930  
that I last saw him alive on 2-26-1930

and that death occurred on the date stated above, at ? m.

The CAUSE OF DEATH \* was as follows:

Still Birth  
(3 month foetus)

Contributory and her husband hit her in the stomach  
Secondary (Duration) 1 yrs. 0 mos. 0 ds.

(Signed) W. C. Claggett M. D.  
2-27-1930 (Address) gaitherburg, Ind.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL on Barnesville DATE OF BURIAL 2-26-1930

20 UNDERTAKER Ernest Claggett ADDRESS Barnesville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scitic," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAR 5 1930  
BUREAU

MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Potomac Park (No. Maple Ave. St. Ward)

2 FULL NAME

Arthur Benton Clark

15133 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 223

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH June 28, 1930  
(Month) (Day) (Year)

7 AGE 5 yrs. 5 mos. 18 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION  
a) Trade, profession or particular kind of work  
b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Washington D.C.

10 NAME OF FATHER Arthur W. Clark

11 BIRTHPLACE OF FATHER (State or country) Nash. D.C.

12 MAIDEN NAME OF MOTHER Elizabeth S. Pope

13 BIRTHPLACE OF MOTHER (State or Country) Nash. D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Arthur W. Clark  
Potomac Park Md.

15 Filed Dec 16 1930 H. C. Rogers  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 16 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 6 1930 to Dec 16 1930

that I last saw him alive on Dec 14 1930

and that death occurred on the date stated above, at 8 A. m.

The CAUSE OF DEATH \* was as follows:

Cerebro Spinal meningitis: sporadic, not epidemic  
(Duration) 1 mos. 11 ds.

Contributory  
Secondary

(Signed) Alfred W. Parsons M. D.  
Dec 16 1930 (Address) Potomac Park D.C.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 5 mos. 18 ds. In the State 1 yrs. 5 mos. 18 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington D.C. Dec 18 1930

20 UNDERTAKER

ADDRESS

H. C. Rogers Adamsburg Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*typhosphul fever* (1) only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "roup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

BUREAU

N B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|   |                                 |   |                                   |  |  |   |  |  |
|---|---------------------------------|---|-----------------------------------|--|--|---|--|--|
| 1 PLACE OF DEATH<br>County <u>Montgomery</u>  |                                 |   | 04440<br>(101-a)                  |  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |  |
| Village or City <u>Seneca</u> (No. ....)  |                                 |   | St. ....                          |  |  | Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.) |  |  |
| 2 FULL NAME <u>Emma Clark</u>   |                                 |   | Registration Dist. No. <u>213</u> |  |  |   |  |  |
| PERSONAL AND STATISTICAL PARTICULARS  |                                 |   |                                   |  |  |   |  |  |
| 3 SEX<br><u>female</u>  | 4 COLOR OR RACE<br><u>black</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widow</u> |                                   |  |  |   |  |  |
| 6 DATE OF BIRTH <u>unknown</u><br>(Month) (Day) (Year)  |                                 |   |                                   |  |  |   |  |  |
| 7 AGE <u>49</u> yrs. <u>0</u> mos. <u>0</u> ds. or <u>1</u> day <u>0</u> hrs. <u>0</u> min. If LESS than 1 day  |                                 |   |                                   |  |  |   |  |  |
| 8 OCCUPATION<br>(a) Trade, profession or particular kind of work <u>domestic duty</u><br>(b) General nature of industry, business, or establishment in which employed or (employer)                                       |                                 |   |                                   |  |  |   |  |  |
| BIRTHPLACE (State or country) <u>Mo.</u>  |                                 |   |                                   |  |  |   |  |  |
| PARENTS   |                                 |   |                                   |  |  |   |  |  |
| 10 NAME OF FATHER <u>unknown</u>  |                                 |   |                                   |  |  |   |  |  |
| 11 BIRTHPLACE OF FATHER (State or country) <u>unknown</u>   |                                 |   |                                   |  |  |   |  |  |
| 12 MAIDEN NAME OF MOTHER <u>unknown</u>   |                                 |   |                                   |  |  |   |  |  |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>unknown</u>   |                                 |   |                                   |  |  |   |  |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Josie Castle</u><br>(Address) <u>Pennantown, Md Route 2</u>  |                                 |   |                                   |  |  |   |  |  |
| 15 Filed <u>4/13</u> 19 <u>30</u> <u>Mrs. W. T. Reelt</u> Registrar   |                                 |   |                                   |  |  |   |  |  |
| MEDICAL CERTIFICATE OF DEATH  |                                 |   |                                   |  |  |   |  |  |
| 16 DATE OF DEATH <u>4-10-30</u><br>(Month) (Day) (Year)   |                                 |   |                                   |  |  |   |  |  |
| 17 I HEREBY CERTIFY, That I attended the deceased from <u>April 3-1930</u> to <u>April 10-1930</u> , that I last saw her alive on <u>April 9-1930</u> and that death occurred on the date stated above, at <u>8 A.</u> m. |                                 |   |                                   |  |  |   |  |  |
| The CAUSE OF DEATH * was as follows:<br><u>Lobar Pneumonia</u><br>(Duration) <u>2</u> yrs. <u>8</u> mos. <u>8</u> ds.   |                                 |   |                                   |  |  |   |  |  |
| Contributory Secondary <u>✓</u><br>(Duration) <u>4-10-1930</u> yrs. <u>0</u> mos. <u>0</u> ds. (Signed) <u>W. C. Wiley</u> M. D.  |                                 |   |                                   |  |  |   |  |  |
| *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.   |                                 |   |                                   |  |  |   |  |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)<br>At place of death <u>4-10-1930</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>4-10-1930</u> yrs. <u>0</u> mos. <u>0</u> ds.  |                                 |   |                                   |  |  |   |  |  |
| Where was disease contracted, if not at place of death? <u>Former or usual residence</u>  |                                 |   |                                   |  |  |   |  |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Seneca</u> DATE OF BURIAL <u>4/13, 1930</u>  |                                 |   |                                   |  |  |   |  |  |
| 20 UNDERTAKER <u>Warner Humphrey</u> ADDRESS <u>Reville</u>   |                                 |   |                                   |  |  |   |  |  |



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word, or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 8 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

08139

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

214

Village or City

Garrett Park

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Josephine Louise Cleveland

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

July 26, 1866  
(Month) (Day) (Year)

7 AGE

63

64 yrs.

1 mos.

20 ds.

If LESS than  
1 day hrs.  
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

D.C.

10 NAME OF FATHER

Thos Kane

11 BIRTHPLACE OF FATHER

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Margaret Quill

13 BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Cleveland

(Address)

Garrett Park Md

15

Filed

July 16, 1930

1930

W. W. Deale

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 16, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from July 1, 1930, to July 16, 1930 that I last saw her alive on July 16, 1930

and that death occurred on the date stated above, at 5 P. m.  
The CAUSE OF DEATH \* was as follows:

Carcinoma of the Stomach

(Duration) 1 yrs. 1 mos. 7 ds.

Contributory secondary

Acute nephritis &amp; Uraemia

(Duration) 1 yrs. 1 mos. 3 ds.

(Signed)

W. W. Deale M. D.

192 (Address) Kensington Md

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Washington D.C.

DATE OF BURIAL

July 18, 1930

20 UNDERTAKER

W. W. Deale

ADDRESS

Washington

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by falling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. 3

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Kensington (No. \_\_\_\_\_)2 FULL NAME Luman M. Cleveland

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH July 19, 1853  
(Month) (Day) (Year)

7 AGE 76 yrs. 11 mos. 15 ds. If LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Clerk  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) New York

10 NAME OF FATHER Orin Cleveland

11 BIRTHPLACE OF FATHER (State or country) New York

12 MAIDEN NAME OF MOTHER Sarah Marsh

13 BIRTHPLACE OF MOTHER (State or country) Vermont

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma A. Cleveland(Address) Kensington, Md.

15 Filed 7-5-1920 Mrs. H. T. Platt  
Registrar

08140

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 213

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 4, 1920  
(Month) 4 (Day) 4 (Year) 1920

17 I HEREBY CERTIFY, That I attended the deceased from Feb 1, 1920 to July 4, 1920.

that I last saw him alive on July 4, 1920.

and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH \* was as follows:

Arterio Sclerosis  
myocarditis

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory Uraemic Heart Failure  
Secondary

(Signed) Oliver Bliss M. D.  
July 5, 1920 (Address) The Kensington Branch of

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rock Creek Cemetery July 7<sup>th</sup>, 1920

20 UNDERTAKER ADDRESS

Harmon C. Humphrey, Rockville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (rarely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH   |   |   | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |                                    |
|--|---|---|---|------------------------------------|
| County <u>Montgomery</u>   |   |   | Registration Dist. No. <u>223</u>   |                                    |
| Village or City <u>Takoma Park</u> (No. <u>400</u> )   |   |   | St. <u>1st</u> Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.) |                                    |
| 2 FULL NAME <u>Jeremiah Bowen Clymer</u>   |   |   |   |                                    |
| PERSONAL AND STATISTICAL PARTICULARS   |   |   |   |                                    |
| 3 SEX<br><u>Male</u>   | 4 COLOR OR RACE<br><u>White</u>                                 | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED<br>(Write the word) <u>Widower</u> |   |                                    |
| 6 DATE OF BIRTH <u>Jan 22, 1862</u><br>(Month) (Day) (Year)  |   |   |   |                                    |
| 7 AGE <u>68</u> yrs. <u>4</u> mos. <u>12</u> ds. If LESS than 1 day hrs. or min.?  |   |   |   |                                    |
| 8 OCCUPATION<br>(a) Trade, profession or particular kind of work <u>Teacher</u><br>(b) General nature of industry business, or establishment in which employed or (employer)   |   |   |   |                                    |
| 9 BIRTHPLACE (State or country) <u>Bluffton Ohio</u>   |   |   |   |                                    |
| PARENTS  | 10 NAME OF FATHER <u>A. H. Clymer</u>                           |   |   |                                    |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>Bluffton Ohio</u> |   |   |                                    |
|  | 12 MAIDEN NAME OF MOTHER <u>Anna Bowen</u>                      |   |   |                                    |
|  | 13 BIRTHPLACE OF MOTHER (State or Country) <u>Ohio</u>          |   |   |                                    |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE   |   |   |   |                                    |
| (Informant) <u>Washington Say &amp; Hosp. Records</u>  |   |   |   |                                    |
| (Address) <u>Takoma Park Md.</u>   |   |   |   |                                    |
| 15 Filed <u>June 6, 1930</u> <u>H. B. Rogers</u> Registrar   |   |   |   |                                    |
| MEDICAL CERTIFICATE OF DEATH   |   |   |   |                                    |
| 16 DATE OF DEATH <u>June 4, 1930</u><br>(Month) (Day) (Year)   |   |   |   |                                    |
| 17 I HEREBY CERTIFY, That I attended the deceased from <u>June 4, 1930</u> to <u>June 4, 1930</u><br>that I last saw him alive on <u>June 4, 1930</u><br>and that death occurred on the date stated above, at <u>10:30 A.M.</u><br>The CAUSE OF DEATH * was as follows:<br><u>Acute Myocarditis</u><br>(Duration) yrs. mos. ds.<br><u>Chronic Nephritis</u><br>for <u>4 years</u> (Duration) yrs. mos. ds.<br>(Signed) <u>H. B. Rogers</u> M. D.<br><u>June 4, 1930</u> (Address) <u>Takoma Park</u> |   |   |   |                                    |
| *State the disease causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.  |   |   |   |                                    |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)   |   |   |   |                                    |
| At place of death yrs. mos. ds. In the State yrs. mos. ds.   |   |   |   |                                    |
| Where was disease contracted, if not at place of death?  |   |   |   |                                    |
| Former or present residence  |   |   |   |                                    |
| 19 PLACE OF BURIAL OR REMOVAL <u>Dr. Findlay Ohio</u>  |   |   |   | DATE OF BURIAL <u>June 6, 1930</u> |
| 20 UNDERTAKER <u>H. B. Rogers</u>  |   |   |   | ADDRESS <u>Wash. D.C.</u>          |

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

06819

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pauper, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Stricterment of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

B. & O.  
J. J. Clymer

RECEIVED  
JUL 5 1920  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed Apr. 10 1930 Upton D. House  
RegistrarSTATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 213

St.: Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from 6 Apr 1930 to 9 Apr 1930

that I last saw him alive on 9 Apr 1930

and that death occurred on the date stated above, at 9 p.m.

The CAUSE OF DEATH \* was as follows:

Broncho pneumonia

(Duration) - yrs. - mos. 4 ds.

Contributory  
SecondarySigned) Stanley W. Barber M. D.  
10 Apr 30 Address) Fairbury, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 8 mos. 28 ds. In the State Same yrs. mos. ds.

Where was disease contracted, if not at place of death? Saint

Former or usual residence Saint

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
German town Md 11 Apr 193020 UNDERTAKER ADDRESS  
Warner Pumphrey Rockville Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or marriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 8 1950  
BUREAU

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County MontgomeryVillage or City Chevy Chase, Md. (No. 29 Drummond Ave. St.        Ward       )2 FULL NAME Charles R. Cochrane

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower  
(Write the word)

6 DATE OF BIRTH April 10, 1856  
(Month) (Day) (Year)

7 AGE 74 yrs. 4 mos. 28 ds. If LESS than 1 day,        hrs. OR        min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)       

9 BIRTHPLACE (State or country) Winchester, Tenn.

10 NAME OF FATHER Chas. P. Cochrane

11 BIRTHPLACE OF FATHER (State or country) Georgia

12 MAIDEN NAME OF MOTHER Jane Estill

13 BIRTHPLACE OF MOTHER (State or country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harold D. Scantlin(Address) 29 Drummond Ave.

15 Filed 9-8-1930 Phonograph REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 216

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9 - 7, 1930  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Only at time of death, 1930

that I last saw him alive on       , 1930and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(Duration)        yrs.        mos.        ds.  
Contributory Severely  
Secondary       

(Signed) Wm. F. Burdick, M. D.  
9-8, 1930 (Address) 3725 Jennifer St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death        yrs.        mos.        ds. State        yrs.        mos.        ds.

Where was disease contracted,

If not at place of death?

Former or usual residence Birmingham, Alabama

19 PLACE OF BURIAL OR REMOVAL Birmingham, Ala. DATE OF BURIAL Sept 8, 1930

20 UNDERTAKER Dr. Lawler's Sons Inc. ADDRESS 1754 Park Ave. N.W.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeeper*s who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," singularly indefinite); *Tuberculosis of lungs*, *melancholia*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

0861  
1  
MAY 1917

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

Village or City

American University Park

2 FULL NAME

Joseph J Collins

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

m

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Widowed

6 DATE OF BIRTH

unknown, 1848  
(Month) (Day) (Year)

7 AGE

82 yrs. - mos. - ds. or min.?If LESS than  
1 day hrs.  
The CAUSE OF DEATH \* was as follows:

8 OCCUPATION

(a) Trade, profession or  
particular kind of workRetired(b) General nature of industry  
business, or establishment in  
which employed or (employer)farmer

9 BIRTHPLACE

(State or country)

Washington Dis; Columbia10 NAME OF  
FATHERJames Collins11 BIRTHPLACE  
OF FATHER

(State or country)

Wash. DC12 MAIDEN NAME  
OF MOTHERMary Payne13 BIRTHPLACE  
OF MOTHER

(State or Country)

DC

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James E Collins

(Address)

American Uni Park

15

Filed 12-23 1930Buyer Perry

Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 214

St. Ward

(If death occurred in  
a hospital or institution,  
give its NAME in-  
stead of street and  
number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 21, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

August 19, 1930, to Dec 21, 1930,  
that I last saw him alive on Dec 20, 1930,and that death occurred on the date stated above, at 3 2 m.

The CAUSE OF DEATH \* was as follows:

Pericious Anemia(Duration) 3 yrs. - mos. - ds.Contributory  
Secondary

(Duration) yrs. - mos. - ds.

(Signed)

J M McChesney M. D.Dec 22 30 (Address) 3421 Wood Avenue\*State the Disease Causing Death, or, in deaths from  
Violent Causes, state (1) Means of Injury and (2) Whether  
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-  
ients or Recent Residents)At place  
of death yrs. - mos. - ds.In the  
State yrs. - mos. - ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethesda MdDec 23, 1930

20 UNDERTAKER

ADDRESS

Geo W Wise Co Wash DC

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 6 1931

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

04442

(62)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 212Village or City Martinsburg (No.     )St.      Ward      (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Chas Colman

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Apr 23, 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 2 min. If LESS than 1 day. hrs. 2 min. or 2 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work not any  
(b) General nature of industry business, or establishment in which employed or (employer)     

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Leonard Colman

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Anna Dorsey

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Dorsey  
(Address) Buckhannon md

15 Filed Apr 24 1930 E.W. White  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 23, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from no physician, 1930, that I last saw him alive on afternoon, 1930, and that death occurred on the date stated above, at 5:23 P.M.  
The CAUSE OF DEATH \* was as follows:

(Prolonged labor of mother) Cyanotic Refractoriness.  
(Duration) 0 yrs. 0 mos. 2 min.

Contributory  
Secondary

(Signed) E.W. White (Duration)      yrs.      mos.      ds.  
Apr 24 1930 (Address) Proberville M. D.

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death      yrs.      mos.      ds. In the State      yrs.      mos.      ds.

Where was disease contracted, if not at place of death?

Former or usual residence     

19 PLACE OF BURIAL OR REMOVAL Martinsburg DATE OF BURIAL Apr 24, 1930

20 UNDERTAKER Chas Dorsey ADDRESS Buckhannon

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *sho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renaliet wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 6 1930

BUREAU



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH   |                                 |  | 13911          |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH  |  |
|--|---------------------------------|--|----------------|--|--|--|
| County <u>Montgomery</u>   |                                 |  | (49)           |  | Registration Dist. No. <u>16</u>   |  |
| Village or City <u>Friendship Heights</u> (No. <u>313</u> )  |                                 |  | <u>Willard</u> |  | Ward) <u>Ave</u> (If death occurred in a hospital or institution, give its NAME instead of street and number.) |  |
| 2 FULL NAME <u>Benjamin F. Constantine</u>   |                                 |  |                |  |  |  |
| PERSONAL AND STATISTICAL PARTICULARS   |                                 |  |                |  |  |  |
| 3 SEX<br><u>Male</u>   | 4 COLOR OR RACE<br><u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Married</u> |                |  |  |  |
| 6 DATE OF BIRTH<br><u>Jan.</u> <u>15</u> <u>1860</u><br>(Month) (Day) (Year)   |                                 |  |                |  |  |  |
| 7 AGE<br><u>70</u> yrs. <u>10</u> mos. <u>16</u> ds. or min.?  |                                 |  |                |  |  |  |
| 8 OCCUPATION<br>(a) Trade, profession or particular kind of work <u>Printer</u><br>(b) General nature of industry business, or establishment in which employed or (employer)   |                                 |  |                |  |  |  |
| 9 BIRTHPLACE (State or country) <u>Buffalo, N. Y.</u>  |                                 |  |                |  |  |  |
| 10 NAME OF FATHER <u>Unknown</u>   |                                 |  |                |  |  |  |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>  |                                 |  |                |  |  |  |
| 12 MAIDEN NAME OF MOTHER <u>Fannie Constantine</u>   |                                 |  |                |  |  |  |
| 13 BIRTHPLACE OF MOTHER (State or Country) <u>England</u>  |                                 |  |                |  |  |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE   |                                 |  |                |  |  |  |
| (Informant) <u>Addie Constantine</u>   |                                 |  |                |  |  |  |
| (Address) <u>313 Willard Ave</u>   |                                 |  |                |  |  |  |
| 15 Filed <u>Nov. 17</u> <u>1930</u> <u>Benz C. Perry</u> Registrar   |                                 |  |                |  |  |  |
| MEDICAL CERTIFICATE OF DEATH   |                                 |  |                |  |  |  |
| 16 DATE OF DEATH <u>Nov 16</u> <u>1930</u><br>(Month) (Day) (Year)   |                                 |  |                |  |  |  |
| 17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> , that I last saw him alive on <u>192</u> , and that death occurred on the date stated above, at <u>2 P.</u> m. The CAUSE OF DEATH * was as follows:<br><u>Carcinoma Bladder</u> |                                 |  |                |  |  |  |
| Contributory Secondary (Duration) yrs. mos. ds.  |                                 |  |                |  |  |  |
| (Signed) <u>Dr. J. S. Starn</u> M. D.<br><u>11/17/30</u> (Address) <u>Bethesda, Md.</u>  |                                 |  |                |  |  |  |
| State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.   |                                 |  |                |  |  |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)   |                                 |  |                |  |  |  |
| At place of death yrs. mos. ds. In the State yrs. mos. ds.   |                                 |  |                |  |  |  |
| Where was disease contracted, if not at place of death?  |                                 |  |                |  |  |  |
| Former or usual residence  |                                 |  |                |  |  |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Washington, D.C.</u> DATE OF BURIAL <u>Nov 18</u> <u>1930</u>   |                                 |  |                |  |  |  |
| 20 UNDERTAKER <u>H. H. Hewins</u> ADDRESS <u>Wash. D.C.</u>  |                                 |  |                |  |  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer 75, retired 6 yrs*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-pulmonary* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

DEC 6 1930

BUREAU V

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as *Asthenia*, *Anaemia* (merely symptomatic), *Atrophy*, *"Collapse"*, *"Coma"*, *"Convulsions"*, *"Debility"* ("Congenital," *"Senile,"* etc.), *"Dropsy"*, *"Exhaustion"*, *"Heart failure"*, *"Haemorrhage"*, *"Inanition"*, *"Marasmus"*, *"Old Age"*, *"Shock"*, *"Uræmia"*, *"Weakness"*, etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as *"PUERPERAL septicæmia"*, *"PUERPERAL peritonitis"*, etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, "delirius"*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 6 1930

BUREAU

MARGIN RESERVED FOR BINDING

WRITE EARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Mont

03090

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City

Spencerville

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

William H Cook

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Col

5 SINGLE,  
MARRIED,  
OR DIVORCED  
(Write the word)

Mar

6 DATE OF BIRTH

Jan 30 1930  
(Month) (Day) (Year)

7 AGE

59 yrs. 1 mos. 9 ds. or min.?

If LESS than  
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF

FATHER

Bronson Cook

11 BIRTHPLACE

OF FATHER

(State or country)

Md

12 MAIDEN NAME

OF MOTHER

Mary Pratt

13 BIRTHPLACE

OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roland Cook

(Address)

Spencerville RFD

15

Filed Mar 11 1930 C. S. Barnard  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar 9th 1930  
(Month) 9 (Day) 9 (Year) 30

17 I HEREBY CERTIFY, That I attended the deceased from

Mar 3 1930 to Mar 9th 1930.

that I last saw him alive on Mar 8th 1930.

and that death occurred on the date stated above, at 8:40 p.m.

The CAUSE OF DEATH \* was as follows:

Sobar Pneumonia

(Duration) yrs. mos. 6 ds.

Contributory  
Secondary

Myocarditis

(Duration) yrs. mos. ds.

(Signed) C. S. Barnard M. D.

Mar 10 1930 (Address) Sandy Springs

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandy Springs

Mar 11, 1930

20 UNDERTAKER

ADDRESS

E. W. Snowden

Rockville

\* If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

her issued.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH *Montgomery*  
County *Prince George's* (45)  
Village or City *Ches. T. Cooley* (COOLEY) No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.) Registration Dist. No. *214*

2 FULL NAME *Ches. T. Cooley*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *W* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Married*

6 DATE OF BIRTH *Jan 29 1869* (Month) (Day) (Year)

7 AGE *61* yrs. *5* mos. *8* ds. or min. If LESS than 1 day \_\_\_\_ hrs.

8 OCCUPATION (a) Trade, profession, particular kind of work *Retired Police Chap. & Paucers* (b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) *Md*

10 NAME OF FATHER *Levin Corley*

11 BIRTHPLACE OF FATHER (State or country) *Md*

12 MAIDEN NAME OF MOTHER *Caroline Thomas*

13 BIRTHPLACE OF MOTHER (State or Country) *Md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) \_\_\_\_\_ (Address) \_\_\_\_\_

15 Filed *7-8* 19*30* *W. L. Lewis* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 7, 1930* (Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from *Jan 25 1929* to *July 7 1930* that I last saw him alive on *July 4 1930* and that death occurred on the date stated above, at *4:15 P.M.* The CAUSE OF DEATH \* was as follows: *Carcinoma of the*

Contributory (Duration) yrs. mos. ds. *10*

Signed *E. W. Jones* M. D. (Address) *Flower 70a*

\*State the Disease causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL *Deeridgee, Md* DATE OF BURIAL *July 30*

20 UNDERTAKER *E. W. Jones* ADDRESS *Deeridgee, Md*

If more blanks are needed, address State Registrar, 15 W. Saratoga St., Balto., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

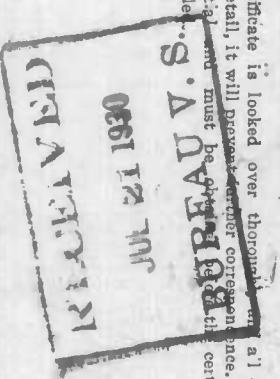
(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonoeum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *HWhooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as provoked such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Montgomery

06820

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

214

Village or City

Silver Spring Md. (No. 757 Sil Spgs Ave)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Martin L. Cooley

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

White5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)married

6 DATE OF BIRTH

Oct51890

(Month)

(Day)

(Year)

7 AGE

59 yrs.1 mos.5 ds.If LESS than  
1 day.....hrs.  
or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Sta Eng. Ret

(b) General nature of industry business, or establishment in which employed or (employer)

U. S. Govt

9 BIRTHPLACE

(State or country)

Maryland10 NAME OF  
FATHERRobert J. Cooley

11 BIRTHPLACE

OF FATHER  
(State or country)Maryland12 MAIDEN NAME  
OF MOTHERMary A. Leasley13 BIRTHPLACE  
OF MOTHER  
(State or Country)Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Esther Cooley

(Address)

757 Sil Spgs Ave Silver Spring Md

15

Filed

June 10 1930J. E. Dondrup  
Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 10<sup>th</sup>, 1930  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased ~~from~~on June 10, 1930 to June 10, 1930  
that I last saw him alive on June 10, 1930and that death occurred on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH \* was as follows:

Angina Pectoris  
(Sudden death)(Duration) 1 yrs. 1 mos. 1 da.Contributory  
SecondaryArteriosclerosis with  
hypertension (Duration) 3 yrs. 1 mos. 1 da.(Signed) J. H. Howell M. D.June 10 1930 (Address) 928 Sil Spgs Ave Silver Spring Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds.

In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wash. D. C.June 10, 1930

20 UNDERTAKER

ADDRESS

W. W. Deal  
Washington D. C.716 - 41 st NE  
Wash. D. C.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia, Bronchopneumonia ("Pneumonia,"*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

03091

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 22Village or City Near Potomac (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME George Edward Cooper

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH November 5, 1929  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. 4 mos. 23 ds. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) D. C.

10 NAME OF FATHER Emory Trymond

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER Ellie Cooper

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Cooper(Address) Bethesda R. F. D.

15 Filed 3/29 1930 hrs. W. T. Pratt  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 27, 1930 to March 29, 1930.

that I last saw him alive on March 27, 1930.

and that death occurred on the date stated above, at 11:59 m.

The CAUSE OF DEATH \* was as follows:

Pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

Contributory Secondary Influenza

(Signed) G. V. Hartley M. D.

March 29, 1930 (Address) Rockville

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Glenn, Md (Union Wesley) March 31

20 UNDERTAKER ADDRESS

C. R. Snowden Rockville, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a)

*Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
APR 7 1930  
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Mont

Village or City

Olney

(No. \_\_\_\_\_)

2 FULL NAME

Calvin Copeland

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

col

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

sing

6 DATE OF BIRTH

Sept 16 1930

(Month)

(Day)

(Year)

7 AGE

yrs. 0 mos. 0 ds. or min.?

If LESS than

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE  
(State or country)

Md

10 NAME OF  
FATHER

Ed Carter

11 BIRTHPLACE  
OF FATHER  
(State or country)

Md

12 MAIDEN NAME  
OF MOTHER

Florence E Copeland

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Florence E Copeland

(Address)

Olney Md

15

Filed Sept 17 1930 C. B. Barnley

Registrar

10528

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 217

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 16 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Sept 16 1930 to Sept 16 1930

that I last saw him on Sept 16 1930

and that death occurred on the date stated above, at 6:00 a.m.

The CAUSE OF DEATH \* was as follows:

Stillbirth

(Duration) 0 yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

C. C. Smithson

M. D.

Sept 16 1930 (Address) Sandy Spring Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Zion Cem

Sept 17 1930

20 UNDERTAKER

ADDRESS

Mathew Copeland Olney, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a)—*Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Melas* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—occident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 4 1930  
BUREAU V. 28

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City Blair (No. 812 Richmond Ave St. 2 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Myron G Cowgill

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 214

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH July 2, 1981  
(Month) (Day) (Year)

7 AGE 17 yrs. 7 mos. 21 ds. or min. ?  
If LESS than 1 day hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work Clerk  
(b) General nature of industry business, or establishment in which employed (or employer) U.S. Post Office

9 BIRTHPLACE (State or country) W Va

10 NAME OF FATHER John M Cowgill

11 BIRTHPLACE OF FATHER (State or country) W Va

12 MAIDEN NAME OF MOTHER Margaret Hiett

13 BIRTHPLACE OF MOTHER (State or Country) W Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ada V Cowgill

(Address) Blair Ma

15 Filed Feb 24 1980 F. E. Wadley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 23, 1980  
(Month) 23 (Day) 1980 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 14, 1980 to Feb 23, 1980

that I last saw him alive on Feb 23, 1980

and that death occurred on the date stated above, at 7:40 p.m.  
The CAUSE OF DEATH \* was as follows:

Lobar Pneumonia

(Duration) 14 yrs. 14 mos. 14 ds.

Contributory  
Secondary

(Duration) 14 yrs. 14 mos. 14 ds.

(Signed) Alfred C. Horcross M. D.  
2/23 1980 (Address) 819 Jayto NW Wash, DC

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 14 yrs. 14 mos. 14 ds. In the State 14 yrs. 14 mos. 14 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Falls Church Va DATE OF BURIAL 2-25-1980

20 UNDERTAKER Geo W Wise Co ADDRESS Wash DC



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

BUREAU V. C.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Montgomery

03092

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 216Village or City Bethesda (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Hugh B. Craig

## PERSONAL AND STATISTICAL PARTICULARS

|                      |                                 |   |
|----------------------|---------------------------------|---|
| 3 SEX<br><u>male</u> | 4 COLOR OR RACE<br><u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word)<br><u>married</u> |
|----------------------|---------------------------------|---|

6 DATE OF BIRTH  
July 9, 1864  
(Month) (Day) (Year)7 AGE  
65 yrs. 8 mos. 3 ds. or LESS than 1 day \_\_\_\_ hrs. \_\_\_\_ min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Lawyer  
(b) General nature of industry, business, or establishment in which employed or (employer) \_\_\_\_\_9 BIRTHPLACE  
(State or country) Pennsylvania10 NAME OF FATHER William B. Craig11 BIRTHPLACE OF FATHER  
(State or country) Pennsylvania12 MAIDEN NAME OF MOTHER Catherine Singer13 BIRTHPLACE OF MOTHER  
(State or Country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Boyd Craig(Address) 1107-16th St. N.W., Wash. D.C.15 Filed Mar 12 1923 Benj. C. Perry  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 12<sup>th</sup>, 1923  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Mar. 2 1923 to Mar. 12<sup>th</sup> 1923, that I last saw him alive on Mar 12<sup>th</sup>, 1923and that death occurred on the date stated above, at 4 a. m.  
The CAUSE OF DEATH \* was as follows: Carcinoma - IntestinalContributory  
Secondary (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.(Signed) Benj. C. Perry M. D.  
Mar 12 1923, (Address) Bethesda, Md

\*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Shippensburg, Pa. DATE OF BURIAL Mar. 13, 192320 UNDERTAKER Warner C. Pumphrey ADDRESS Rockville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinster*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E-haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
APR 5 1930  
BUREAU OF VITAL STATISTICS

MARGIN RESERVED FOR BINDING  
WRITE IN ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Montgomery

10529

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 218Village or City Germananton (No. ....)

St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William L. Lenanford

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)6 DATE OF BIRTH 11-2-1854  
(Month) (Day) (Year)7 AGE 76 yrs. 10 mos. 22 ds. If LESS than 1 day, hrs. or min.?8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Md10 NAME OF FATHER Hamilton Lenanford11 BIRTHPLACE OF FATHER (State or country) Md12 MAIDEN NAME OF MOTHER Elizabeth Higgins13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Chas Bowman  
(Address) Germananton Md15 Filed 9/25 1930 Prachel Dare Etchem  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9-24-1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 8/15-1930 to 9/24-1930, that I last saw him alive on 9/24-1930, and that death occurred on the date stated above, at 3.30 P.m. The CAUSE OF DEATH \* was as follows:Myocarditis  
(Duration) 6 yrs. 6 mos. 6 ds.Contributory Secondary Arterio Sclerosis  
(Duration) 2 yrs. 2 mos. 2 ds.(Signed) J. A. Simpson M. D. 9/25 1930 (Address) Gaithersburg Md

\*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 6 yrs. 6 mos. 6 ds. In the State 6 yrs. 6 mos. 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Keelsville Md DATE OF BURIAL 9/26-193020 UNDERTAKER E. L. Gantner ADDRESS Gaithersburg Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archibae, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.* (*Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a) questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

OCT 6 1930

BUREAU V. D.



MARGIN RESERVED FOR BINDING

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montg.

Village or City Polomac (No. ....)

2 FULL NAME John William Creamer

05691 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. .... Ward .... (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH May 26, 1853  
(Month) (Day) (Year)

7 AGE 77 yrs. 0 mos. 0 ds. If LESS than 1 day .... hrs. or .... min.?

OCCUPATION  
(a) Trade, profession or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed or (employer) .....

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John. B. L. Creamer

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nancy Selvey

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) John. T. Creamer  
(Address) Polomac Md

15 Filed 5/28/1920 W. T. Price  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 26, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 1, 1920 to May 1, 1920, that I last saw him alive on May 1, 1920, and that death occurred on the date stated above, at 10 30 A. M.

The CAUSE OF DEATH \* was as follows:  
Arteriosclerosis, Chronic Myocarditis  
(Duration) 5 yrs. .... mos. .... ds.

Contributory Secondary None  
(Duration) 5 yrs. .... mos. .... ds.

(Signed) Wm. G. Lathrop M. D.  
May 28, 1920 (Address) Rockville, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Polomac Chapel DATE OF BURIAL May 28, 1920

20 UNDERTAKER W. R. Humphrey Jr ADDRESS Rockville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women, at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County MontgomeryVillage or City Rockville (No. Waverley Sanatorium)Registration Dist. No. 216

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Blanche George Cressey

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word)Married

## 6 DATE OF BIRTH

Sept. 1, 1980  
(Month) (Day) (Year)

## 7 AGE

70 yrs. 1 mos. 3 ds. OR 1 day, 3 hrs. 15 min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Vermont

## PARENTS

## 10 NAME OF FATHER

John Frank George

## 11 BIRTHPLACE OF FATHER

(State or country)

Vermont

## 12 MAIDEN NAME OF MOTHER

Sarah Ann Wood

## 13 BIRTHPLACE OF MOTHER

(State or country)

Nova Scotia, Canada

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Capt. Y. S. Williams U.S.N.

(Address)

4701 Connecticut Ave. Wash. D.C.

## 15

Filed

9-3-1930 Thomas K. Canad

REGISTRAR

10530

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Sept 3, 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Sept 3, 1930.that I last saw him alive on Sept 3, 1930.and that death occurred on the date stated above, at 7:15 p. m.

The CAUSE OF DEATH\* was as follows:

Acute cardiac dilatation  
in a chronic mitral  
stenosis(Duration) 33 yrs. 33 mos. 33 ds.Contributory  
SecondaryHypertensive arterio  
sclerosis(Duration) 1 yrs. 1 mos. 1 ds.

(Signed)

Joseph Mel Barth, M. D.9/3/30 (Address) 2700 G St. Wash. D.C.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 4 yrs. 11 mos. 11 ds. In the State 4 yrs. 11 mos. 11 ds.

Where was disease contracted, if not at place of death?

Former or usual residence N. Y.

## 19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington, D.C. 9/3/30

## 20 UNDERTAKER

Joe. Hawley Sons 1754 Pa. Ave. Wash. D.C.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

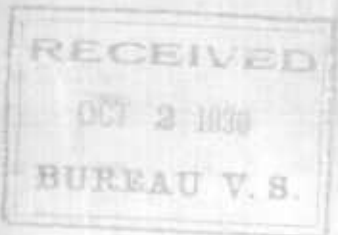
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



1 3/21  
Pat. De mon of ofn rep

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1 PLACE OF DEATH  
County Montgomery

Village or City Beallsville (No. 87-2)

2 FULL NAME Berta A. Crissey

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 212

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH Aug 9 1857  
(Month) (Day) (Year)

7 AGE 73 yrs. 3 mos. 12 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed or (employer).

9 BIRTHPLACE (State or country) va

10 NAME OF FATHER Armistead Silcott

11 BIRTHPLACE OF FATHER (State or country) va

12 MAIDEN NAME OF MOTHER Elizabeth Resser

13 BIRTHPLACE OF MOTHER (State or country) va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Loyd Grubb  
(Address) Beallsville Md

15 Filed 11-23 1930 W. T. Pratt H. B. W. R. Humphrey  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 21<sup>st</sup> 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 1930 to Nov 20<sup>th</sup> 1930, that I last saw him alive on Nov 20<sup>th</sup> 1930, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH \* was as follows:  
Arterial sclerosis (General)

Contributory Secondary Paralysis Agitans  
(Duration) 15 yrs. - mos. - ds.

(Signed) Upton D. Journal M. D.  
Nov 21<sup>st</sup> 1930 (Address) Danville Ky  
\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. - mos. - ds. In the State 3 yrs. - mos. - ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Monacoy Cemetery Beallsville Md DATE OF BURIAL 11/23/1930

20 UNDERTAKER W. R. Humphrey ADDRESS Beallsville Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

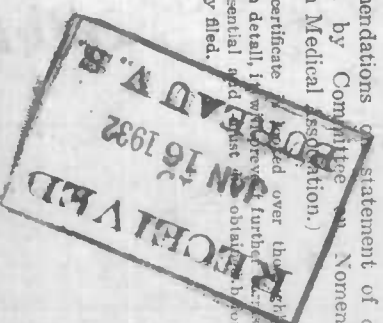
(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*; (b) *Grocery*; (a) *Foreman*; (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home*, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations of statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is copied over the back and all questions answered in detail, it will preserve further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| 1 PLACE OF DEATH  |   |  |
|---|---|--|
| County <u>Montgomery</u>  |   |  |
| Village or City <u>New Kensington</u> (No. _____) St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)  |   |  |
| 2 FULL NAME <u>Infant of James Crockett</u>   |   |  |
| PERSONAL AND STATISTICAL PARTICULARS  |   |  |
| 3 SEX<br><u>male</u>  | 4 COLOR OR RACE<br><u>C</u>                                   | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>single</u>          |
| 6 DATE OF BIRTH<br><u>Apr. 13</u> 19 <u>30</u><br>(Month) (Day) (Year)  |   |  |
| 7 AGE<br>____ yrs. ____ mo. ____ ds. or ____ min. If LESS than 1 day ____ hrs.  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession or particular kind of work <u>none</u><br>(b) General nature of industry, business, or establishment in which employed or (employer) _____  |   |  |
| 9 BIRTHPLACE<br>(State or country) <u>ind.</u>  |   |  |
| PARENTS   | 10 NAME OF FATHER <u>James Crockett</u>                       |  |
|   | 11 BIRTHPLACE OF FATHER<br>(State or country) <u>New York</u> |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Edua Stewart</u>                  |  |
|   | 13 BIRTHPLACE OF MOTHER<br>(State or country) <u>ind.</u>     |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Edua Crockett</u><br>(Address) <u>New Kensington - ind.</u>  |   |  |
| 15 Filed <u>April 14</u> 19 <u>30</u> <u>W. L. Davis</u><br>Registrar   |   |  |
| MEDICAL CERTIFICATE OF DEATH  |   |  |
| 16 DATE OF DEATH<br><u>Apr. 13</u> 19 <u>30</u><br>(Month) (Day) (Year)   |   |  |
| 17 I HEREBY CERTIFY, That I attended the deceased from<br><u>Apr. 13</u> 19 <u>30</u> to <u>Apr. 13</u> 19 <u>30</u><br>that I last saw him alive on <u>Apr. 13</u> 19 <u>30</u><br>and that death occurred on the date stated above, at <u>3 p.m.</u><br>The CAUSE OF DEATH * was as follows:<br><u>Premature birth.</u><br><u>(4 1/2 mos.)</u><br>(Duration) ____ yrs. ____ mos. ____ ds. |   |  |
| Contributory<br>Secondary<br>(Signed) <u>E. G. Bowersford</u> M. D.<br><u>Apr. 14</u> 19 <u>30</u> (Address) <u>Brooklyn, Ind.</u><br>*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.   |   |  |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)<br>At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.<br>Where was disease contracted, if not at place of death?<br>Former or usual residence _____  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL<br><u>Whitson Cem.</u>  |   | DATE OF BURIAL<br><u>April 14</u> 19 <u>30</u><br>ADDRESS<br><u>James Crockett</u> |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "laborer," "foreman," "manager," "dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
MAY 9 1930  
BUREAU

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, precisely. CEAS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

06821

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 214

Village or City \_\_\_\_\_ (No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Laura Jane Cross

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F4 COLOR OR RACE W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word) Married

6 DATE OF BIRTH Apr 22 1857

(Month)

(Day)

(Year)

7 AGE 73yrs. 0mos. 14ds. 1

or

min. 2

8 OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country) MD10 NAME OF FATHER John Mackelney11 BIRTHPLACE OF FATHER (State or country) MD12 MAIDEN NAME OF MOTHER Annabel Cindell13 BIRTHPLACE OF MOTHER (State or Country) MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. H. Rogers(Address) 1000 Spring Hill Rd. Catonsville15 Filed June 5 1930

1930

W. L. S. Registrar  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 5 1930

(Month)

(Day)

19230

I HEREBY CERTIFY, That I have seen the deceased

that I saw him He died suddenly about 10:40 AM  
and that death occurred on the date stated above at 10:40 AM  
The CAUSE OF DEATH was as follows: Acute Myocarditis

Contributor's Signature

(Signed) Dr. J. H. Rogers19230 Address Catonsville

\*State the Cause Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. .... mos. .... ds.

In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

16 PLACE OF BURIAL OR REMOVAL CatonsvilleDATE OF BURIAL June 7 1930FUNERAL DIRECTOR E. H. RogersADDRESS Catonsville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU V. S.



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<sup>1</sup> PLACE OF DEATH  
County Montgomery

14249

⑧

# STATE OF MARYLAND CERTIFICATE OF DEATH

 Registration Dist. No. 217

 Village or City Olney (No. Mont. Co. Gen. Hosp.

 St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME CROWN

## PERSONAL AND STATISTICAL PARTICULARS

|                      |                                 |  |
|----------------------|---------------------------------|--|
| 3 SEX<br><u>Male</u> | 4 COLOR OR RACE<br><u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word)<br><u>single</u> |
|----------------------|---------------------------------|--|

|   |   |
|---|---|
| 6 DATE OF BIRTH<br><u>Nov. 12, 1930</u><br>(Month) (Day) (Year) | 7 AGE<br><u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. or <u>0</u> min.? |
|---|---|

|  |               |
|--|---------------|
| 8 OCCUPATION<br>(a) Trade, profession or particular kind of work<br>(b) General nature of industry, business, or establishment in which employed or (employer) | <u>Infant</u> |
|--|---------------|

|                                    |                  |
|------------------------------------|------------------|
| 9 BIRTHPLACE<br>(State or country) | <u>Maryland.</u> |
|------------------------------------|------------------|

|                   |                       |
|-------------------|-----------------------|
| 10 NAME OF FATHER | <u>Frank M. Crown</u> |
|-------------------|-----------------------|

|   |                  |
|---|------------------|
| 11 BIRTHPLACE OF FATHER<br>(State or country) | <u>Maryland.</u> |
|---|------------------|

|                          |                    |
|--------------------------|--------------------|
| 12 MAIDEN NAME OF MOTHER | <u>Agnes Beall</u> |
|--------------------------|--------------------|

|   |            |
|---|------------|
| 13 BIRTHPLACE OF MOTHER<br>(State or Country) | <u>Ma.</u> |
|---|------------|

|  |  |
|--|--|
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE |  |
|--|--|

(Informant)

(Address)

 15 Filed 192

Registrar

## MEDICAL CERTIFICATE OF DEATH

|  |   |
|--|---|
| 16 DATE OF DEATH<br><u>Nov. 12, 1930</u><br>(Month) (Day) (Year) | 17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> |
|--|---|

|  |  |
|--|--|
| that I last saw h <u>alive</u> on <u>192</u> | and that death occurred on the date stated above, at <u>1:15P</u> m. |
|--|--|

|                                      |                  |
|--------------------------------------|------------------|
| The CAUSE OF DEATH * was as follows: | <u>STILLBORN</u> |
|--------------------------------------|------------------|

|   |                        |
|---|------------------------|
| (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. | Contributory Secondary |
|---|------------------------|

|   |                                    |
|---|------------------------------------|
| (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. | (Signed) <u>Sandy Spring</u> M. D. |
|---|------------------------------------|

|   |  |
|---|--|
| (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. | (Signed) <u>11/12</u> 1923 (Address) <u>Sandy Spring</u> |
|---|--|

|   |  |
|---|--|
| *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. | 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) |
|---|--|

|  |   |
|--|---|
| At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. | In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. |
|--|---|

|   |  |
|---|--|
| Where was disease contracted, if not at place of death? | 19 PLACE OF BURIAL OR REMOVAL<br><u>Body was delivered to the father</u> |
|---|--|

|                           |                             |
|---------------------------|-----------------------------|
| Former or usual residence | DATE OF BURIAL<br><u>19</u> |
|---------------------------|-----------------------------|

|               |         |
|---------------|---------|
| 20 UNDERTAKER | ADDRESS |
|---------------|---------|

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Montg.

Village or City Faithurstburg (No. 1)

2 FULL NAME Infant Crown

04444

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 218

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Wht. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH April 26, 1930  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 1 day 0 hrs. 0 min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work none  
(b) General nature of industry business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Ray L. Crown

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Ray Miller

13 BIRTHPLACE OF MOTHER (State or Country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ray L. Crown

(Address) Faithurstburg

15 Filed April 26 1930 Prochul Darr Station  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 25, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at 192 m.

The CAUSE OF DEATH \* was as follows:

Still born

Contributory  
Secondary

(Signed) Stanley W. Barber M. D.  
26 Apr 1930 (Address) Faithurstburg Ind.

\*State the cause of death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Faithurstburg DATE OF BURIAL April 26, 1930

20 UNDERTAKER Ray L. Crown ADDRESS Faithurstburg

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a] questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 6 1930

BUREAU V. S.

WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Montgomery

Village or City

Silver Spring (No.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 214

If death occurred in a hospital or institution, give its NAME instead of street and number.)

## 2 FULL NAME

Lucile Martha Crutchfield

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

July 4, 1929  
(Month) (Day) (Year)

7 AGE

1 yrs. 0 mos. 9 ds. or min. ?  
If LESS than 1 day....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Philadelphia Pa.

10 NAME OF FATHER

Raymond Solomon Crutchfield

11 BIRTHPLACE OF FATHER

(State or country)

Silver Spring

12 MAIDEN NAME OF MOTHER

Earlaine Webster

13 BIRTHPLACE OF MOTHER

(State or country)

Silver Spring

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earlaine Webster

(Address)

Tin Linnwood Md.

15

File

July 14, 1930 F. E. Dudley

Deputy

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 13, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

July 13, 1930, to July 13, 1930.

that I last saw him alive on July 13, 1930.

and that death occurred on the date stated above, at 5:15 P. M.

The CAUSE OF DEATH was as follows:

Dysentery, catarrhal.

cystitis

(Duration) yrs. mos. 5 ds.

Contributory Secondary

Polar pneumonia

(Duration) yrs. mos. 1 da.

(Signed) Marion Bandhead M.D.

July 13, 1930 (Address) Silver Spring, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.... yrs. .... mos. .... da.

In the State, .... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Belgium Baptist Church

7/14, 1930

20 UNDERTAKER

ADDRESS

(Father) Raymond Solomon Crutchfield Linden Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite"); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asystolia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Central," "Senile," etc.), "Dropy," "Exhaustion," "Organ failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Montg

Village or City

near Poolesville (No. \_\_\_\_\_)

2 FULL NAME

John Cubitt

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write in words)

Single

6 DATE OF BIRTH

Sept 18 1873  
(Month) (Day) (Year)

7 AGE

56 yrs. 9 mos. 12 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Geo W Cubitt

11 BIRTHPLACE OF FATHER

Maryland

12 MAIDEN NAME OF MOTHER

Mary Monred

13 BIRTHPLACE OF MOTHER

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo W Cubitt

(Address)

Poolesville, Md

15

Filed July 1 1930 E. W. H. Registrar

06822

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 212

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 30<sup>th</sup> 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 1929 to June 30, 1930

that I last saw him alive on June 30, 1930

and that death occurred on the date stated above, at 10:40 A.M.

The CAUSE OF DEATH \* was as follows:

Carcinoma of Stomach and liver

(Duration) 1 yrs. 1 mos. 5 ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Upton S. Sproul M.D.

7/1/30 (Address) Poolesville, Md

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Beallsville

DATE OF BURIAL

7/2/30

20 UNDERTAKER

Hallen + Hall

ADDRESS

Poolesville Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of . . . . .* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. hausion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery

Village or City near Wheaton

2 FULL NAME Ammie E. Cunningham

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Sept. 15, 1840  
(Month) (Day) (Year)

7 AGE 90 yrs. 1 mos. 15 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired  
(b) General nature of industry business, or establishment in which employed or (employer) "

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Nathan Kidwell

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Barbara Frizzell

13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles C. Cunningham

(Address) Silver Spring, Md.

15 Filed Nov. 1, 1930 J. E. Dudley Registrar

12875

(74a)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. \_\_\_\_\_ Ward \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 29, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1, 1925 to Oct. 29, 1930, that I last saw him alive on Oct. 29, 1930,

and that death occurred on the date stated above, at 10:30 A.M.,  
The CAUSE OF DEATH \* was as follows:

Ruptured cerebral vessel

(Duration) 7 yrs. 0 mos. 0 ds.  
Contributory arteriosclerosis  
Secondary

(Signed) W. H. Harrison M. D.  
Oct. 29, 1930 (Address) Libby, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 7 yrs. 0 mos. 0 ds. In the State 7 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Obelville M. E. Church Cem. Nov. 1, 1930

20 UNDERTAKER ADDRESS

Warnex E. Humphrey, Rockville, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Assthena," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 8 1930

BUREAU V S



WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Montgomery

05692

STATE OF MARYLAND  
CERTIFICATE OF DEATH

(125)

Registration Dist. No. 223

Village or City Takoma Park, (No. Washington San & Hospital, Takoma Park) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

<sup>2</sup> FULL NAME Mr. Thomas Norman Cunningham

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write this word)

6 DATE OF BIRTH July 30, 1861  
(Month) (Day) (Year)

7 AGE 68 yrs. 9 mos. 20 ds. If LESS than 1 day \_\_\_\_ hrs. 1 day \_\_\_\_ hrs. 2 \_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession or particular kind of work Retired Bookkeeper  
(b) General nature of industry business, or establishment in which employed or (employer) in Wholesale Store

9 BIRTHPLACE (State or country) Fauquier Co. Va.

10 NAME OF FATHER T. M. Norman

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Hume

13 BIRTHPLACE OF MOTHER (State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington San & Hosp. Files  
(Address) Takoma Park, Md.

15 Filed May 21, 1930 H. E. Rogers  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 20, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 13, 1930 to May 20, 1930  
that I last saw him alive on May 20, 1930  
and that death occurred on the date stated above, at 11:45 p.m.

The CAUSE OF DEATH \* was as follows:

Myocardial Weakness  
(Duration) 4 mos. \_\_\_\_ ds.  
Contributory { Fall out of bed  
Secondary { Extraction of teeth  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) Chas. H. Holbrook, M.D.  
5/20/1930 (Address) Takoma Park, Md.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. 8 ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1013 Charles Str. Fredericksburg Va.

19 PLACE OF BURIAL OR REMOVAL Fredericksburg Va. DATE OF BURIAL May 23, 1930

20 UNDERTAKER W. F. Thompson ADDRESS Fredericksburg Va.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Preliminary statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement, never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Maid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.